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ABSTRACT

This document is a compilation of reports of persons involved in the fellowship program offered by the Institute of Health and Human Values. The fellowship program centers around recognition of a need to support faculty development so that appropriately trained people can be available for emerging programs that teach human values as part of health professional education. Four major areas are examined in the fellowship reports. The first deals with values, their formation and dimensions; literature and language in relation to value formation and health care; attitudes, feelings, and values in educating a medical student; and observations on the learning of values in a clinical context. The second area involves the study of ethical issues in medicine, international health, philosophy, and law. Interdisciplinary studies is the focus of the third section of reports. The relations between psychiatry, law, sociology, and health care are exposed. Another report examines participation in an experimental program relating humanistic studies to a premedical curriculum. The last area explores the development of new courses through literature, science, and ethics in biomedical research and health care delivery. (Author/JR)

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Institute on Human Values in Medicine

REPORTS OF THE INSTITUTE FELLOWS 1973–74

May, 1974

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FOREWORD

In June, 1973, the Institute on Human Values in Medicine selected eighteen individuals to whom it awarded its first Fellowships in Human Values and Medicine. Funds for these awards were provided by the National Endowment for the Humanities through its supporting grant to the Institute.

The initiation of this fellowship program reflected the Institute's awareness of the need to support faculty development so that appropriately trained persons can be available for emerging programs for teaching human values as part of health professional education. To teach effectively at the interface of medicine and the humanities requires unusual cross-disciplinary skills, and this is the kind of study that the Institute Fellowships were intended to promote.

Persons already qualified in either the health professions or the humanities were invited to submit proposals for studying a discipline different from, but complementary to, their own. Thus humanists were encouraged to study in a medical or health care setting, while physicians, medical scientists, and other health professionals were encouraged to pursue humanistic studies. Applicants formulated their own goals, designed programs for achieving these goals, and selected the setting in which they felt they could best accomplish their objectives. The tenure of the fellowships varied from individual to individual, but no Fellow received support for more than six months.

After completing their studies, the Fellows reported to the Institute their experiences, accomplishments, reflections, and hopes and plans for the future. Although most of the reports appear here in abbreviated form, the enthusiasm of all of the Fellows for their respective undertakings remains fully stated. Their deep commitment to continuing their involvement in this new area of study, teaching, and research is clear and convincing. Also self-evident in these reports is a remarkable record of personal achievement and professional growth compiled by this first group of Institute Fellows.

It has been a personal pleasure for me during the past year to move through the process of getting acquainted with these men and women, from learning their names as applicants, through working with them as Fellows, to finally coming to know them as persons. I would like to thank them most sincerely for all that I enjoyed with them and all that I learned from them.

Lorraine L. Hunt, Ph.D.
Project Director and Editor
Institute on Human Values in Medicine

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VALUES AND VALUE FORMATION

LARRY R. CHURCHILL

Larry R. Churchill received his formal training in philosophy and religious studies from Southwestern University at Memphis (B.A., Phi Beta Kappa), and in the Divinity School (M.Div., summa cum laude) and the Graduate School (Ph.D.) of Duke University. He has done research and holds strong interest in the philosophy of language, phenomenological studies, epistemology, and the philosophy of religion. Churchill's doctoral dissertation is an effort to display how critical epistemological paradigms have held a superordinate position over the conceptual repertoire of modern, Western man, and especially how such theories of knowing have shaped contemporary problems in the philosophy of language. In this writing he suggests a conceptual shift toward a post-critical philosophy of language based upon the epistemology of Michael Polanyi and Maurice Merleau-Ponty's phenomenology of speaking.

More recently his endeavors have clustered around a range of questions and issues which are axiological, or value-oriented, and which focus explicitly upon how such questions and issues may most appropriately be addressed in the medical setting. His major interest at present involves the effort to articulate a perspective on the ethics of medicine which will not isolate inquiry upon the "decisional edges" of explicitly-held questions and issues. The ethical questions of medicine are, for the physician, mediated through the ethos of his training and practice. Churchill's concern is to describe and evaluate the medical sensibility, i.e., the ethos of epistemic, linguistic, and perceptual commitments which animate the skills and attitudes and inform the work patterns of physicians. This descriptive task-interdisciplinary in terms of both subject matter and methodology--should culminate in a genre for doing medical ethics which grounds ethical issues in medicine's ethological Lebensform.

Churchill is currently teaching in the School of Medicine (Office of Medical Studies) and the Department of Religion, University of North Carolina at Chapel Hill. His writings have appeared in International Journal for Philosophy of Religion, Journal of the American Academy of Religion, North Carolina Medical Journal, et al.

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A STUDY OF THE VALUE DIMENSIONS OF MEDICAL EDUCATION AND PRACTICE

Submitted by

Larry R. Churchill, Ph.D.

My six-month tenure as an Institute Fellow was spent in an effort to become acquainted in detail with the medical community, especially the forces operative within this community which give shape to the self-conceptions, professional norms, and value systems of clinicians. In order to achieve this aim I participated in the routine life and work of the medical community at the University of North Carolina at Chapel Hill at a variety of educational levels within the curriculum and in a number of major specialties. In addition, I spent one week at the new Mayo Medical School, Rochester, Minnesota.

In the preclinical curriculum, I attended especially to a first-year course entitled "Introduction to Medicine"--a course designed to integrate the emerging technical knowledge of the first-year student into a coherent clinical pattern. This course also includes the initial patient contacts for medical students and culminates in patient interviews which are videotaped and reviewed in small groups. This setting obviously provided a rich area for the discernment of the methods by which values, attitudes and professional identities are given initial shape. It is interesting to note that there was for some students a large attitudinal change during this course. Some who initially thought of Introduction to Medicine as a "nice break" from the memorization of the "hard data" later felt that patient interviewing was an "essential" for medical competence.

The clinical years at UNC-CH involve general exposure to the major divisions in medicine, followed by elective work in areas of more concentrated focus. In much of my endeavor I associated myself with a ward team on each of the major rotations (medicine, surgery, pediatrics, obstetrics and gynecology, and psychiatry) for a period of roughly three to four weeks each. During this time I audited seminars, attended rounds, and generally attempted to get a picture of the kinds of relationships and forms of interaction which characterize medical education on a routine level. I made a special effort to attend to the manner in which third- and fourth-year students are apprenticed in the professional attitudes, norms, and life styles exemplified by their mentors. There was hardly a day in which some question of substantial ethical import was not raised or enacted in the complex reticulum of house staff relationships with patients and with each other.

I am continuously impressed by the powerful forces which lie embedded within the routines of training and care, and by the depth of influence teaching physicians exercise (often tacitly) over those whom they train. It is frequently argued that students come to medical school with their values already "set," and consequently the teaching physicians to whom a student is apprenticed have little influence upon the student's professional ethics. While there is cogency to this position, it fails to see that: 1) the process of medical training itself is not value-free, and to acquire the knowledge necessary to practice medicine is also to adopt the normative framework of that knowledge; 2) men of medicine at least appear to have a heavier investment than other professionals in the legitimacy conferred by their training, status, and work, e.g., the self-identity of the person is more involved with the profession (considering the stresses of their training, it would be strange if this were not so); 3) the experiences of medical training have a deep rite du passage character, and the rituals and customs of practice perpetuate a particular sense of reality. More generally, the notion of a fixed set of values presupposes a view of the person which is essentially static, and oversimplifies the complex processes of growth and maturation as experienced existentially by the individual. Yet perhaps even more persuasive is the articulated concern of some students about the way in which the experiences of medical education have changed them, or altered their perspectives. And it may be helpful to say something as bald as to assert that ethics has as its primitive task a freeing of the professional from the limitations involved in habitually living out of only one perspective.

As is obvious, I believe there is an important and extensive inquiry which involves probing into the ethics enacted within the ethos of medicine. I have indicated my modest beginning into this unexplored topography elsewhere in this report.

Other specific activities of my tenure were grand rounds, death conferences, and innumerable informal conferences with students, house staff and teaching physicians. These conversations, coupled with my observations on the wards, afforded my inquiry a thickness of texture it clearly would not have had otherwise. I feel a general sense of indebtedness to all those who in various ways lended themselves to this inquiry through their willingness to converse and to be observed. I am especially grateful to Dr. James A. Bryan II, who is the person most responsible for my daily entry into the routines of medical life at UNC-CH. Dr. Bryan embodies in his teaching and practice the kinds of emphases which are requisite for humane medicine (though no doubt he would argue strenuously with me about the "ethical" importance of his teaching).

It was also my good fortune to be part of a regular colloquy on the philosophy and sociology of medicine--a product of the imagination of Professor Ruel W. Tyson, Jr., of the Department of Religion. This group (still in existence) consists of medical students, teaching clinicians, social scientists, philosophical and religious ethicists, and others who defy description, representing both UNC and Duke, who are engaged by the questions of the place, status, and function of the humanities and social sciences in medical education. Needless to say, I have profited a great deal from participation in this group. It provided a backdrop of colleagues in my inquiry, and also embodied in its proceedings the angst of persons who share common concerns but speak different dialects.

The week of January 6 was spent in Rochester, Minnesota, at the Mayo Institutions. My purpose in this week was to feel the pulse of a medical school whose ambiance was very different from that of UNC-CH. I was very interested in such questions as: "How does one train a primary care physician in the rarified atmosphere of sub-specialty practice and research?" or "How are social awareness and epidemiological diversity transmitted to students in the setting of private care?" More generally, I was simply interested in learning of the ways in which human value questions were approached and engaged at Mayo. This week was the most intensive I spent during my tenure, every day being utilized to the fullest extent (for which I owe Jack Uhlenhopp many thanks). My entire effort was made possible by the gracious receptivity of Dr. Raymond D. Pruitt, Director of the Division of Education of the Mayo Foundation and Dean of the Medical School.

While there is no formal program in medicine and humanities in the Mayo Medical School curriculum, there is an openness to such considerations and a strong interest among some faculty and administration. Dr. Pruitt is a rare combination of physician and humanist, and his deep calling to speak the "language in which faculty can convey to students their commitment to the humane" gives a distinctive tone to the educational endeavors of the new medical school. Much time was spent during this week talking with teaching physicians about their influence on their students, about the questions listed above, and about the task of medical education generally. Additionally, talks with Deans Gerald Needham and Ward Fowler were beneficial in gaining insight into admissions policies and student problems. This week was a very beneficial one for me personally, as well as for my research.

The question, "How does this compare with what you had planned to do when you applied?" admits at least three answers. 1) I did precisely what my application said I would do, viz., a study of the value dimensions of medical education and practice through an analysis of the language in which doctor-patient relationships are couched, with a special focus upon the value assumptions embedded in these conversations. 2) I also found that the accomplishment of 1) was intrinsically related to a cluster of other inquiries, which I all-too-readily began pursuing simultaneously. In particular, I found myself enticed by the sensibility of the physician, i.e., the characteristic ways in which the sensorium of the physician is altered or reoriented by his training and what epistemic and perceptual biases are packed into his skills. Language seems the obvious point of entry for these studies as well, so that this more broad spectrum of concerns relate to the analysis of language as the more specific focus of my inquiry. 3) As an additional point of entry into the clinical sensibility and its value implications, I began to explore sociological studies. My initial identification with the patients on the wards soon gave way to a primary identification with the physicians and an adoption of their angle of vision upon doctor-patient relationships. To better understand this transition--which I assume is characteristic of most medical students at some point early in their career--I pored through such things as Berger and Luckmann's The Social Construction of Reality, the sociology of medicine studies of the 1950's (Merton, et al., The Student-Physician, Becker, et al., Boys in White) several works of Irving Goffman, Dorothy Emmet, Renée Fox, Eliot Freidson, etc., as well as extraneous articles on emergent physicianhood.

I believe that sociology of medicine studies are valuable commentary upon the ethical dimensions of medicine, but these studies need interpolation. The most deep-seated ethic of the clinician is that one which he enacts in the routines of the ward and which he "learned" by apprenticing himself to his clinical mentors. Sociological works are rich sources for an inquiry into these areas, but the reading of these texts with a critical eye for their implicit value strata is what distinguishes the inquiry I deem important from both the sociology of medicine and medical ethics (where the latter is an explicit and systematic inquiry into the decisional edge of exotic issues.) Such issues are, for the physician, lived experiences of his work and are thus mediated to him quite differently than for the ethicist or the social scientist. Again, social forms and ethological norms as a means for approaching the value dimensions in medicine are discernible through a careful study of language. Much which is not said in language is yet shown through language through the patterns of speech-habits, the pet analogues, and the unself-conscious metaphors for "doctoring" which figure the ethics of practice. In short, delving into the language of doctor-patient conversations is also to delve into the social and ethological forms which these conversations bespeak and routinely re-enact. Or to put it differently, medical ethics has a double valence--the more catenarian, formalized issues for focal consideration and resolution, and also the reticular social and ethological roots through which these issues are mediated. Language, in the clinical setting, may be said to speak the former and to bespeak the latter.

I do not see the endeavors I have described above as a "substantial change" in the direction of my study, but I do feel it represents an exfoliation of themes and motifs packed into my proposal. Moreover, I believe this extension of my inquiry has important implications for 1) how one goes about a study of the ethics of medicine, and 2) the role of a humanist in the medical setting.

1) There is more than one locus (and more than one appropriate methdology) for the study of the ethics of medicine, and any ethicist--be he physician, patient, or academician--will be conducting a largely trivial inquiry unless he is sensitive to this diversity. Moreover, this sensitivity cannot be confined to the explicit level, nor to well-defined specific differences in approach. Some of the most powerful determinants of the ethics of the clinician lie in the trenchant social and ethological Lebensform of medical training and practice, i.e., at a level difficult to talk about because it is lived within. 2) A fortiori, the humanist, not sharing this Lebensform, has peculiar liabilities which are not bridged by the de facto sharing of Judeo-Christian conceptual assumptions and cultural forms. Hence, the humanist has a special task to become acquainted with the forces which give shape to the epistemic, perceptual, and linguistic predilections of clinicians. Since each of these is an index of his practice, it gives shape to the formalization of issues with ethical import.

I am presently at work on a number of article-length manuscripts which I hope will embody the concerns of my research and possess some heuristic powers for my future involvement in these areas. These all cluster around what I referred to above as the clinical sensibility--the ways physicians are schooled to see themselves and others (especially their patients) and to conceive of their tasks. The overriding telos of this effort, inter alia, is the articulation of a view of medical ethics which is not moribund to Enlightenment paradigms and would therefore enliven the physician's (and the humanist's) ability to reconceive of his humanus. These writings are addresed to both clinicians and academic ethicists; a few tentative titles might help to convey where I think this kind of research is headed: "Ethos and Ethics in Medical Education", "Value Strata in the Speech of the Clinician: A Commentary on the Clinical Sensibility", "The Canny Eye of the Clinician" (concerning his perceptual skills), "Learning the Scope of Responsibility: A Critical Look at House Staff Relations".

I am convinced that there are large areas of work which have not been given adequate attention, and powerful currents in the educational processes of medicine which are unacknowledged, because our regnant theories of education are too impoverished to imagine them. As a result the "ethics" of medicine becomes largely an ad hoc enterprise of those physicians who "by nature" are inclined to critical reflection and value sensitivity--things which are not highly prized in most medical curricula. For many physicians (and laymen as well) ethical considerations are still external frills and embellishments upon the scientific hardware, and ethics as a discipline, while it may come to bear in abortions and euthanasia, is conceived to be externally related to the routines of clinical care. Whatever my future research and teaching may entail, its larger telos will be the legitimation of critical reflection and axiological sensitivity in a cultural milieu designed to systematically discredit it.

Syllabus and Course Description *

"Medicine and Human Values"
Religion 196 F. 2 & 3
Duke University - Spring, 1974

Instructor: Larry R. Churchill

I. Introduction

II. Background: Some Assumptions of Modern Scientific Thought and Their Implications for Human Values

E. A. Burtt. The Metaphysical Foundations of Modern Physical Science (Anchor, 1954), pp. 63-124.

Hans Jonas. The Phenomenon of Life. (Delta, 1966), First Essay, Third Essay.

A. N. Whitehead. Modes of Thought. (Macmillan, 1968), Part III, "Nature and Life".

_______. Science and the Modern World. (Macmillan, 1967), Chapters 2 & 3.

Ian Barbour. Issues in Science and Religion. (Prentice-Hall, 1966). pp. 15-44.

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* My teaching of premedical students at Duke in "Medicine and Human Values" is an endeavor to bring to bear upon medicine the perspectives of several disciplines, among them philosophy of science, religious ethics, sociology of medicine, and some literature that germinated from the clinical setting.

This course constitutes a new offering which is a direct result of my study as an Institute Fellow, and hopefully will be expanded to include other courses. I feel its most distinctive mark is the emphasis upon critical reflection about the process of emergent physicianhood by those about to embark upon this regimen --an emphasis which is not self-evident from reading the syllabus. The response has been superb.

III. Persons and Values in the Medical Setting

David Reiser, "Struggling to Stay Human in Medicine" The New Physician, May, 1973.

Robert M. Veatch, "Models for Ethical Medicine in a Revolutionary Age," Hastings Center Report, June, 1973.

Sociology of Medicine packet

IV. Human Values in Medicine: A Religious Perspective
Harmon Smith, Ethics and the New Medicine, Preface and chapter 1.

V. Science, Persons and Human Values: A Reconsideration
Michael Polanyi, The Study of Man (Chicago Phoenix, 1963).

VI. The Personal Dimension of Medicine: An Exploration

VII. Focus on Human Experimentation in Medicine
Daedalus, Spring, 1969, Articles by Guido Calabresi, Louis Lasagna, Geoffrey Edsall & Jay Katz.

VIII. Focus on Human Experimentation in Medicine
Daedalus, Spring, 1969, Articles by Hans Jonas and Herman L. Blumgart.

"The Patient's Bill of Rights"

IX. Focus on Human Experimentation in Medicine
H. Smith, Ethics and the New Medicine, Chapter 3.

X. Dying and Death: The Modern Predicament
tape: "Problems in The Meaning of Death"

Joseph W. Matthews, "The Time My Father Died", The Modern Vision of Death, Nathan Scott (ed.)

XI. Dying and Death: Process and Event
R. S. Morison, "Death: Process or Event", Science, August 20, 1971.

Leon R. Kass, "Death as an Event: A Commentary on Robert Morison", Science, August 20, 1971.

Dallas M. High, "Death: Its Conceptual Elusiveness" Soundings, Winter, 1972.

XII. Dying and Death in the Clinical Setting
Nancy L. Caroline, "Dying in Academe", The New Physician, November, 1972.

Literary packet

A case study

XIII. Dying and Death in the Clinical Setting
Elizabeth Kubler-Ross, On Death and Dying

XIV. Death and Care of the Dying
H. Smith, Ethics and the New Medicine, Chapter 4.

A Selected Bibliography of Works Read During the Fellowship Period
(articles not included)

Becker, Howard S., Blanche Geer, Everett C. Hughes and Anselm Strauss. *Boys in White: Student Culture in Medical School*. Chicago: Univ. Press, 1961

Berger, Peter L. & Thomas Luckmann. *The Social Construction of Reality*. Garden City: Anchor Doubleday, 1967.

Daedalus. Spring, 1969. "Ethical Aspects of Experimentation with Human Subjects".

Emmet, Dorothy. *Rules, Roles and Relations*. New York: Macmillian, 1967.

Enelow, A.J. & Scott Swisher. *Interviewing and Patient Care*. New York; Oxford University Press, 1972.

Goffman, Erving. *Asylums*. New York: Anchor Doubleday, 1961

______. *Encounters*. Indianapolis: Bobbs-Merrill, 1961.

______. *Strategic Interaction*. Philadelphia: Univ. Penn. Press, 1969

Fox, Renèe C. *Experiment Perilous*. Glencoe, Ill.: The Free Press, 1959.

Foucault, Michel. *The Birth of the Clinic: An Archaeology of Medical Perception*. Trans. by A.M. Sheridan Smith. New York: Pantheon, 1973.

Jaco, E. Gartly. *Patients, Physicians and Illness*. Glencoe, Ill.: The Free Press, 1958.

Jonas, Hans. *The Phenomenon of Life*. New York: Dell, 1966.

Mendelsohn, Everett, Judith Swazey and Irene Taviss. (eds.) *Human Aspects of Biomedical Innovation*. Cambridge: Harvard Univ. Press, 1971.

Merton, Robert, George Reader & Patricia Kendall. *The Student-Physician: Introductory Studies in the Sociology of Medicine*. Cambridge: Harvard Univ. Press, 1957.

Mumford, Emily. *Interns: From Students to Physicians*. Cambridge: Harvard, 1970.

Ramsey, Paul. *The Patient as Person*. New Haven: Yale, 1970.

Freidson, Elliot. *Professional Dominance: The Social Structure of Medical Care*. Atherton Press, 1970.

Notes from Readings in the Literature of the Social and Behavioral Sciences

Submitted by

Larry R. Churchill, Ph.D.

What we conceptually identify ourselves with and say we are thinking at any time is the centre; but our full self is the whole field, with all those indefinitely radiating subconscious possibilities of increase that we can only feel without conceiving, and can hardly begin to analyze. The collective and the distributive ways of being coexist here, for each part functions distinctly, makes connections with its own peculiar region *in the still wider rest of experience* and tends to draw up into that line, and yet the whole is somehow felt as one pulse of our life, --not conceived so, but felt so.

William James, "The Continuity of Experience," *The Writings of William James*, etc. John McDermott, Modern Library, pp. 294-96 (sequence changed and italics added)

In this pragmatic, frenetic existence he [the student] may quickly absorb the moral atmosphere around him without questioning it. It is my conviction, therefore, that ethical problems must be integrated into the doctor's life at the earliest possible moment. I do not believe that it will be effective to bring up such matters relatively late in the medical career, although the doctor will certainly require constant reinforcement throughout his professional life. The medical student must be made, from the beginning, to consider the ethical aspects of medicine, in regard to both practice and research. Many a liver biopsy is performed in the name of science, with little benefit to the patient. A medical student made emotionally immune to the casual performance of risky procedures by the tacit acceptance of such procedures by his mentors is unlikely to be excessively concerned as a physician or investigator with the subtleties of ethical or moral issues. Some way must be found to incorporate these matters so firmly into his moral fabric that he cannot avoid the ethical implications of his acts. I submit that the successful development of such an ethical conscience, combined with professional skill, will protect the patient or experimental subject much more effectively than any laws or regulations.

Louis Lasagna, "Some Ethical Problems in Clinical Investigation," in Human Aspects of Biomedical Innovation, Cambridge: Harvard, 1971, pp. 108-09.

"The students have expected that once they arrive in the clinical years they will be able to realize the idealistic ambitions they had to help people... But they find themselves working to understand cases as medical problems rather than working to help the sick and memorizing all the available relevant facts so that these can be produced immediately for a questioning staff man....

Observers speak of the cynicism that overtakes the student and the lack of concern for his patients as human beings. This change does take place, but it is not produced by 'the anxiety brought about by the presence of death and suffering.' The student becomes preoccupied with the technical aspects of the cases he deals with because the faculty requires him to. He is asked about enough technical details that he must spend most of his time learning them."

H. S. Becker and Blanche Geer, "The Fate of Idealism in Medical School", E. Gartly Jaco (ed.) Patients, Physicians and Illness. p. 304.

"As a result of the increasing technical aspects of his thinking the student appears cynical to the non-medical outsider, though from his own point of view he is simply seeing what is "really important."

Patients, Physicians and Illness,
p. 305

"No current code of medical ethics defines how the individual rights of the patient can be preserved in the complicated nexus of relationships which characterizes team care."

p. 83

"The physician's traditional role as helper and his new role as scientist are of necessity brought into potential conflict."

p.84

"Without ever explicitly saying so, existing medical codes are designed to protect the rights of man as defined in the Judeo-Christian and Greek concepts of man as 'person' with a certain special destiny."

p. 90

"The philosophical assumptions underlying the practical directives of ethical codes are rarely specified. The codes instead have concerned themselves with how to act."

p. 90

"To date there has been little deliberate effort to sensitize each physician to the modalities of ethical discourse or to acquaint him with the complexities of the value decisions he makes daily. Indeed, medical faculties are inclined to see ethical and metaethical questions as vague and insubstantial. The recourse is too often to apodictic statements and simplistic solutions. Customarily, we have depended upon the admirable but insufficient Hippocratic ethic and the more contemporary codes which are derived from it. The answer is not to be found in additional coursework in medical ethics or more humanities in college. These facile prescriptions have failed repeatedly to make physicians more humane or more moral."

pp. 94-95

"Students need to see in the actions of their teachers a concern for ethical questions equal to their concern for mechanisms of disease and their management... The metaethical questions of the 'good' and the 'right' are best explored in the context of specific problems encountered in providing care for individuals or communities."

p. 95

"All this calls for a deeper involvement of social scientists and humanists in medical education. This will not be easy to effect. Social scientists and humanists are too inclined to think in terms of 'courses', when what is needed is involvement in concrete clinical situations and the exchanging of views with clinicians and students. The social scientist and the humanists must become practitioners of their disciplines, to a certain extent."

p. 95

Edmund D. Pellegrino, "Physician, Patients and Society: Some New Tensions in Medical Ethics", Human Aspects of Biomedical Innovation, Cambridge: Harvard, 1971.

"...he comes to feel like a physician more through identifying with his colleagues than through his relationship with his patients. He may become less subject to discomfort over the way a patient responds to him, but he is likely to stay relatively alert to approval from his colleagues."

Emily Mumford, Interns: from Students to Physicians,
Cambridge: Harvard, 1970. p. 119.

"Three-fourths of the Community Hospital respondents [in a survey of interns], but none of the University Hospital respondents said they attached great importance to ability to establish rapport with patients. This is consistent with a tendency for house staff members at University Hospital to speak of "our patient", in contrast with the clarity with which nurses and interns at Community refer to "Dr. Jones' patient."

p. 134

"Commitment to rapport and the patient-physician relationship introduces a special problem that may be generated when physicians become very concerned with approval from patients... With rather high "psychic income" from establishing rapport with and "caring for" patients, in a double sense, the practitioner may become so concerned with the relationship that he is overzealous in maintaining it."

p. 185

"This commitment to the relationship may help the doctor's responsiveness to his patient, but as with other commitments, the relationship can become an end in itself. When this happens some larger medical goals get temporarily lost."

p. 186

"The social context creates occasions for rewards and losses that support certain aspects of medical manners and behavior over some other aspects. It is not that excellence of medical standards or specialization in a teaching hospital blunts compassion in a dedicated physician. It is, rather, that the physician already tending to handle the patients' fears by denying them, may be assisted in the unfortunate direction by environmental factors that facilitate his moving away via respectable concentration on discourse of the disease."

p. 188

"The physician-instructor's attitudes toward the patients and students appear to be the most significant force in shaping the outcome of the medical identity."
Mendel, W.M. & G.A. Green "On Becoming a Physician",
J. Med. Ed., 1965.

"The notion of role, therefore, I suggest provides a link between factual descriptions of social interactions and moral pronouncements about what ought to be done in them."
D. Emmet, Rule Roles and Relations, Macmillan, 1966, p. 41

"By virtue of the role he plays the individual is inducted into specific areas of socially objectivated knowledge, not only in the narrow cognitive sense, but also in the sense of the "knowledge" of norms, values and even emotions."

"To learn a role it is not enough to acquire the routines immediately necessary for its "outward" performance. One must also be initiated into the various cognitive and even affective layers of the body of knowledge that is directly and indirectly appropriate to this role."
Peter Berger and Thomas Luckmann, The Social Construction of Reality,
Doubleday Anchor, 1967, p. 77.

"...the individual does not go about merely going about his business. He goes about sustained to constrain a viable image of himself in the eyes of others. Since local circumstances always will reflect upon him, and since these circumstances will vary unexpectedly and constantly, footwork, or rather selfwork, will be continuously necessary."
Erwing Goffman, Relations in Public, Haper Colophon, 1971. p. 185.

"...almost every activity that an individual easily performs now was at some time for him something that required anxious mobilization of effort. To walk, to cross, a street, to utter a sentence, to wear long pants... all these routines that allow the individual unthinking, competent performance were attained through an acquisition process whose early stages were negotiated in a cold sweat... To speak here of the individual learning a skill, procedure, or a mode of perception entirely intellectualizes the acquisition process. The individual's ease in a situation presumes that he has built up experience in coping with the threats and opportunities occuring in the situation. He acquires a survivably short reaction time--the period needed to sense alarm, to decide on a correct response, and to respond. And as a result, he has not so much come to know the world around him as he has become experienced in coping with it."
Goffman, pp. 248-49.

role-validation: the role given to a person, the one he is expected to live up to, the one which gives him the distinct notions operative in that community of what is appropriate and what is not.

Role-commitment: the complementary process whereby a person adopts the expected style of behavior as his own, committing himself to the role themes expected of him by his peers or superiors.

Goffman, p. 341ff.

"...individuals tend to develop a self-image which reflects the image others have of them...students who noted that their patients assigned to them the role of physician were more likely than others to think of themselves as doctors."

"It was further found that, within this context, the requirements of the patient also affected the development of the professional self-image of the student. The opportunity to act in the role of quasi-physician facilitated the sense of growing doctorhood."

M.J. Huntington, "The Development of a Professional Self-image," Student-Physician, p. 187.

"...it is useful to think of the process of role acquisition in two broad classes; direct learning through didactic teaching of one kind or another, and indirect learning, in which attitudes, values and behavior patterns are acquired as by-products of contact with instructors and peers, with patients, and with members of the health team. It would seem particularly useful to attend systematically to the less conspicuous and more neglected process of indirect learning... Students learn not only for precept, or even from deliberate example; they also learn--and it may often be, most enduringly learn--from sustained involvement in that society of medical staff, fellowstudents and patients which makes up the medical school as a social organization."

R. K. Merton, "Some Preliminaries to a Theory of Medical Education", Student-Physician, pp. 41-2.

"...a janitor does not experience the same disgust with garbage as the layman and an undertaker does not turn away from a corpse with a laymen's revulsion. Instead they see garbage and corpses as technical problems to be dealt with in the appropriate way. The technical vocabulary and point of view furnish an alternative way of experiencing the event and spare the professional anxiety or discomfort the lay perspective suggests as an appropriate response."

H. S. Becker, et. al. Boys in White, Chicago Univ. Press, 1961. p. 272.

Goethe's Axiom: we see only what we look for; we look for only what we know.

VALUES GOVERNING THE PHYSICIAN-PATIENT RELATIONSHIP

1. The physician must be emotionally detached in his attitudes toward patients, keeping "his emotions on ice" and not becoming "overly identified" with patients.

   BUT: he must avoid becoming callous through excessive detachment, and should have compassionate concern for the patient.

2. The physician must not prefer one type of patient over another, and must curb hostilities toward patients (even those who prove to be uncooperative and who do not respond to his therapeutic efforts).

   BUT: the most rewarding experience for the physician is the effective solution of a patient's health problems.

3. The physician must gain and maintain the confidence of the patient.

   BUT: he must avoid the mere bedside manner which can quickly degenerate into expedient and self-interested salesmanship.

4. The physician must recognize that diagnosis is often provisional.

   BUT: he must have the merited confidence of the patient who wants "to know what is really wrong" with him.

5. The physician must provide adequate and unhurried medical care for each patient.

   BUT: he must not allow any patient to usurp so much of his limited time as to have this be at the expense of other patients.

6. The physician should come to know patients as persons and give substantial attention to their psychological and social circumstances.

   BUT: this too should not be so time-consuming a matter as to interfere with the provision of suitable care for other patients.

7. The physician should institute all the scientific tests needed to reach a sound diagnosis.

   BUT: he should be discriminating in the use of these tests, since these are often costly and may impose a financial burden on patients.

8. The physician has the right to expect a "reasonable fee", depending on the care he has given and the economic circumstances of the patient.

   BUT: he must not "soak the rich" in order to "provide for the poor."

9. The physician should see to it that medical care is available for his patients whenever it is required.

   BUT: he, too, has a right to a "normal life" which he shares with his family.

from The Student-Physician, Merton, R.K.

Reader, G.R. & Kendall, P.L. (eds.) Cambridge: Harvard, 1957.
pp. 74-75.

ETHOS AND ETHICS IN MEDICAL EDUCATION*

by

Larry R. Churchill

> Professional work of any sort tends to narrow the mind, to limit the point of view, and to put a hallmark on a man of a most unmistakable kind.[1]

A humanist undertaking a study of the value dimensions in medical education meets with a wide variety of responses. After explaining the purpose of my study to a third-year medical student he replied: "There's no time to learn values here; what we have to learn is how to be competent physicians. The old family doctor was great with his patients, but let's face it--he simply didn't know any medicine."

Such a response--not universal, yet not atypical--is itself a commentary upon the value transmission in medical education. Yet it is a widely held opinion that the learning of values is something that is accomplished in formal course work (or, alternatively, from one's parents in early childhood) when the focus is upon "ethics" in the same manner in which one might study Romantic poets, or gross anatomy. It could be argued that such an opinion finds its source, philosophically, in the rise of modern scientific thought in the seventeenth century and in the epistemology of René Descartes, i.e., in the depersonalization of knowledge, the distrust and alienation of the senses from the noetic situation, and the elevation of mathematics as the model for a precise tool of inquiry. I do not wish to argue that historical case here. I do wish to suggest that despite the predilection to consider facts and knowledge as totally distinct from values, the experiences of medical education constitute a workshop for values. Medical sociologists have been aware of this for some time, yet this insight has not been systematically cashed out in terms of the philosophy of medicine and especially not in terms of all that falls under the rubric "medical ethics."

It will be useful initially to distinguish between an *ethical system*, composed of explicitly-held rules, formulae, and moral principles, and a nexus of *ethological norms or values*.[2] Such values are quite often loosely identified, seldom find articulate form, and generally operate inconspicuously in the routines of a given community. An ethos is the characteristic spirit, the prevalent tone of sentiment, or the special genius of a community. Etymologically there is a common root for the terms "ethos" and "ethic," suggesting a normative dimension to an ethos and the germination of a specific, formalized ethic out of the character of the community and its sub-cultures. I wish to suggest that it will be important to view the medical community and its various sub-cultures of specialty ethologically and to inquire into its moral and intellectual norms. The ethological norms of the medical community are not the sole determinants of the physician's sense of care, responsibility, the ethics of practice, etc.--but they are very powerful determinants and they are largely unexplored.

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These ethological norms are held tacitly by practicing physicians, and they are reinforced by the sociological shapes of medical work. This means, for example, that the expectations for doctor-patient relationships, on the part of both physicians and patients, are so strongly grounded in custom and so widely accepted as to seem "natural" or self-evidently "right." In this case the value dimensions of any given doctor-patient interaction can be more-or-less read off the requirements of the social situation. That is, the notion of what is and is not within the sphere of the physician's responsibility, or even what constitutes appropriate conduct is already understood and unreflectively endorsed. Hence, the power that ethological norms hold over the actions of any community is at least partially derived from the tacit status such norms occupy within the work of that community.

In medical education these norms are transmitted largely (and most powerfully) through the characteristic forms of practice as these are indwelled by apprenticeship of the student-physician. That is, these norms are transmitted largely through the models, metaphors, and paradigms which inform the routine practices of physicians. In this way teaching physicians know and teach more than they can explicitly say. The value dimensions of the medical ethos cannot be taught, for the same reasons that virtue cannot be taught, but they can be shown. That of which the teaching physician cannot exhaustively speak, he bespeaks through the character of his actions. The informal, unarticulated role manifestations, the professional modeling unassumingly performed by attending physicians and senior house staff, is far more powerful in transmitting values and attitudes to medical students than any of the formal, explicit desiderata of their teaching.

Together these ethological norms make up the professional self-image with its attendant expectations and preoccupations. This phenomenon can be put sociologically as a study of the "role" of the physician and the learning of this role by the student-physician. The gravamen of my thesis is that "role" is both a descriptive and a normative term, and furthermore that the normative dimensions of a role are often deep-seated tacit components in the formulation of surface, explicitly ethical questions.

I suggest that not all the important norms of the medical ethos are presently identified (or even identifiable) and few, if any, have been explored systematically. For example, little work has been done on the perceptual, epistemic, and linguistic norms which make up the sensibility of physicians. One norm which is well-identified and which relates ubiquitously to patient care is variously termed "detached concern,"[3] "disinterested sympathy,"[4] "empathy and affective neutrality,"[5] and other terms which suggest a balance between the distance necessary for professional competence and the concern which lies at the heart of patient care. This complex norm is particularly important because it relates to the widest possible range of doctor-patient relationships; indeed, it gives shape to the whole spectrum of doctor-patient contacts.

An inquiry into the nature of this norm as it operates ubiquitously in the training of medical students could serve as a point of entry into the professional self-image generally, and into the characteristic ways in which the medical ethos schools its initiates to view man, the human body, care, responsibility, etc. Hence, an inquiry into this norm and its ethological habitat is an important place to begin an inquiry into medical ethics.

All the phrases mentioned above to describe this norm conjoin two distinct sets of ideas.

detached: unfastened, separated, disengaged, disconnected
disinterested: impartiality, unbiased as to the possibilities
affective neutrality: emotionally (as opposed to cognitively) uncommitted, having unbiased feelings

concern: to have a share, interest or part with
sympathy: sameness of feelings, not necessarily implying approval
empathy: sympathy, but with a retention of awareness of the other

No doubt many physicians function comfortably and effectively within this norm, and if this is so, I suggest it is because they have found it to be workable and valuable in terms of the routine performance of their tasks. Indeed, it is primarily because of its wide acceptance and endorsement by physicians that it deserves serious critical attention. Additionally, it seems that the complex nature of this attitudinal norm makes it susceptible to misunderstanding. Hence, in what follows I shall tentatively explore what this norm predisposes student-physicians to think about themselves, conceptually, and how it predisposes them to act, practically.

On the conceptual level, this two-faceted norm predisposes the student-physician to a fragmentation that divides his knowledge (*qua* cognition) and his attitudes (affective dimensions), and completely dissociates the latter from the skilled utilization of the former. A typical division in the articulation of the aims of medical education specifies knowledge, attitudes, and skills. While this division is theoretically useful, it easily lends itself to a formal reification which ignores the interplay of all these factors in the most modest and routine doctor-patient interchange. Yet fragmentation is only the first stage in the process of achieving a true dualism, which occurs when the fragmented elements of a person's sensibility are acknowledged to be divorced into two antithetical clusters, and when this dichotomy constitutes a standard for practice.

In summary, the more fundamental difficulty involved with this complex norm is that it predisposes the student-physician to a paradigmatic division between his competence and effectiveness as a physician and the affective dimensions of his skills. The physician operates most effectively when he dissociates his cognitive content and his affective acuity--so this high paradigm suggests. To be sure, the model obligates the physician to establish rapport, trust, and an affective relationship with his patients.

The gravamen of my critique of this model is that this level of affectivity between doctor and patient is usually conceived to have a totally external relation to the physician's knowledge, or to the skilled utilization of such knowledge. A resident once admitted that he treats patients callously on morning work rounds, but he quickly added that some member of the ward team goes back to see these patients later in the day, and then they are treated differently. It follows that this physician, who has achieved the paradigmatic disaffiliation in his work, should be admired as one admires a performer who achieves difficult feats with one hand behind him.

Yet the thesis that the complex ethological norm discussed here easily lends itself to a conceptual dualism would be insignificant without a recognition that conceptual presuppositions often find practical predispositions. A visiting professor of pediatrics, addressing the house staff on infant resuscitation, asked who among them would inject an alkaline solution after five minutes of lack of spontaneous breathing and heartbeat.

After a brief pause roughly half raised hands in assent. The professor's question of "Why?" was answered by a resident in terms of the balance of body chemistry, muscle stimulation, and the like. The professor then asked this resident if he was aware that the chances of substantial, irreversible damage after five minutes were great, and that the divorce rate after one year for parents of such children in a major U.S. city is approximately fifty per cent. Whether the resident was actually aware of these statistics is important. Yet more fundamental is the fact that a question which is prima facie answerable on strictly patho-physiological grounds is seen to require an answer on ethical grounds.

What deserves attention here is the degree to which the interpersonal and social dimensions of medicine can become habitally secondary, even tertiary--not out of conscious design, neglect, or any premeditated ordering of priorities, but because the ethological norms which give shape to his training predispose him to such a conceptual dualism and to a practical preoccupation with quantifiable reality. Detachment is easily translatable, in the practical ordering of a crowded schedule, into total disengagement from the life of the patient. Disinterest easily slips into uninterestedness in the routines of the ward and under the pressures of being assessed on grounds which discredit the non-formalizable facets of professional competence.

A senior medical student spoke in the emergency room of the value of his military experience in preparing him for medical school. Responding to his accounts of medicine on the battle front, I remarked that one must get accustomed to seeing men maimed and dying. "Sure," he replied, "I can eat my lunch off a corpse."

It is not my purpose here to explore how medicine teaches its initiates to cope with the phenomenon of death. I only want to note the commonplace: the experiential toll of medical education, as well as the toll in terms of finances and energies, is high. Therefore, affective distancing is a prerequisite. Such experiences as venipuncture, physical examinations, experimentations with animals, and autopsies lenghten this distance and enlarge its domain as a technique of the profession. Even the use of highly specialized, technical language can be utilized as an instrument for affectively displacing oneself in order to proceed professionally with the work. Hence, it should not seem surprising if some students feel relief upon being told by a teaching physician that in spite of their idealized image of the physician, "You are really just well-trained, highly paid technicians."

The norm of detachment, distance, or disinterest is powerful because it is sociologically in accord with the regnant paradigm for any truly scientific undertaking.

"Disinterest," "detachment," and "affective neutrality" are all terms used to designate the professional distance necessary for the achievement of therapeutic goals. Such a distance is indispensable. Yet to couch this professional attitude primarily in terms of a discreditation of emotions, feelings, and untidy perceptual awareness creates more problems than it solves, since it easily becomes a ubiquitous philosophical commitment divorced from its particular function and specific telos in patient care. This telos is the achievement of diagnostic and therapeutic goals, which are patient-specific and grounded in particular concrete problems of care. Detachment becomes debilitating when it becomes a free-floating professional style, or an aegis from critical self-examination. Detachment limits the personal (non-professional) involvement of doctor with patient, protecting both parties, preserving the physician's judgment, yet prohibiting him from becoming judgmental toward the patient.

Yet the affective dimension is one of the most fecund, and it gives depth and insight into more formalized medical knowledge. Professional detachment will become counter-productive to the extent that it renders impotent the perceptual acuity inherent in the emotional dimensions of understanding and caring for others. Following this line of reasoning, what the student-physician must learn is not to demonstrate both detachment and concern, or even to balance the two disparate poles of this norm. Rather, the goal is to integrate them as effective tools for medical practice. Such an integrative feat will require space for critical reflection upon the process of medical education by those in training and endorsement of the development of such skills in students by teaching physicians.

One way to begin to understand and assess medical education is to ask, with reference to the student-physician: what models, paradigms, and conceptions of himself are made available to him through the experiences, frameworks, and shapes of interaction which characterize the medical educational process? If the insights of affectivity, the skills of a teleologically-grounded concern, and the diagnostic powers of personal values have been relegated to a secondary status in medicine, it is not because our theory has been inadequate (though it has). It is rather because the ethological commitments of medicine have endorsed this order of priorities through the forms of work and the experiences of training. It follows that the primary (though not the exclusive) impetus for changing or reordering these priorities lies with physicians themselves. But in attempting to make a place for the wide range of non-quantifiable dimensions in medical education mentioned above, altering the conceptual grounds on which such dimensions can be legitimated is a beginning.

FOOTNOTES

1. William Osler, The Master-Word in Medicine, annotated and with Introduction by Charles G. Roland (Springfield: Charles C. Thomas, 1972), p. 27.

2. I am indebted to Professor Ruel W. Tyson, Jr., University of North Carolina at Chapel Hill, for inviting my attention to the ethos of medicine.

3. "Detached concern" reflects the sociology of medicine studies of the 1950s; see especially The Student-Physician, edited by Robert K. Merton, *et al.* (Cambridge: Harvard, 1957) and the work of Renée C. Fox, University of Pennsylvania.

4. "Disinterested sympathy" was suggested to Dorothy Emmet in her efforts to unpack the notion of "role" for the study of ethics in Rules, Roles and Relations (New York: Macmillan, 1966), *passim*.

5. "Empathy and affective neutrality" is a phrase garnered from Dr. Robert S. Lawrence, School of Medicine, University of North Carolina at Chapel Hill.

LINDA P. DRISKILL

Linda Phillips Driskill holds B.A., M.A., and Ph.D. degrees in English. She is a Renaissance poetry and applied linguistics specialist interested in exploring new ways in which the skills of a traditional discipline, the study of language and literature, may be applied to enhance medical education, to improve the quality of health care, and to augment the research techniques now used to explore areas of population study such as desired family size, acceptance of birth control methods, and the relative personal utility of children to women of different ethnic, economic, and occupational groups. Believing that the function of English studies has been too narrowly conceived, she has attempted to define new uses for literary and critical skills.

In association with Dr. Joseph Meyerowitz of Baylor College of Medicine in Houston, she has devised a new psychotherapy technique, narrative skills therapy, which had positive results in experimental use at a large Houston hospital with patients in a drug abuse program and with other patients receiving psychiatric treatment. The results of this work have been accepted for publication in Hospital and Community Psychiatry.

At Rice University in Houston Dr. Driskill teaches in the English Department and is the director of the experimental program in composition. The program employs a new approach to writing improvement developed by Dr. Driskill, based on the learning of evaluative concepts the student can apply to his own writing. The program offers a self-paced, individualized program of writing improvement quite different from the traditional rule-centered, imitative method of composition instruction.

In looking for new applications and functions for the study of language and literature, Dr. Driskill tries to overcome the isolation imposed by old boundaries developed over the years by specialized disciplines. She believes that analyzing problems from multiple intellectual perspectives frequently generates more effective solutions for those problems. She contends, however, that the use of multiple perspectives demands a keen respect for the conceptual integrity of each approach, and a strict awareness of the purposes and limits of each discipline. First she attempts to analyze situations and problems in terms of their susceptibility to solutions involving language behavior and the skills taught in language and literary study. Then she relates these analyses to the conceptualizations of these problems created by the assumptions and methods of other disciplines already involved in these areas. "Developing a multidisciplinary approach does not mean departing from one's own specialty," she says, "but seeing its possibilities more clearly in relation to other intellectual systems in order to promote effective collaboration."

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Dr. Driskill is interested in collaboration on future projects involving communications aspects of health care systems, family planning, and literary study in medical education.

LITERATURE AND LANGUAGE, VALUE FORMATION, AND HEALTH CARE

Submitted by

Linda P. Driskill, Ph.D.

In the broadest sense, my purpose during my fellowship has been to explore the possible functions and applications of my own discipline in relation to the interests and concerns of medical education, health care delivery systems, and population studies. Because the study of these broad questions has only recently begun, I tried to be alert to survey the opportunities and challenges to my profession in whatever I read, studied, or observed, keeping the questions of applicable skills, relevant conceptualizations, and adaptable techniques constantly before me, part of the radar for moving through a new field of experience. This mental habit helped me uncover new areas for future work, and led me to experiment with activities beyond the scope of my original plan of study.

Originally, the object of my fellowship was to do the library research and the interdisciplinary study necessary to prepare for directing research related to the concerns of two of the teaching-research units at the University of Texas School of Public Health. The subject of this research project, which I intended to limit and focus more specifically as my familiarity with the field increased, was to be influential factors in attitude change in women, concerning family planning, desired family size, and related topics.

I felt the control of population growth was one of the key factors in any projection of the future, especially in developing countries. Technology alone could not be expected to control population growth. Until the factors and human values that influence family-planning decisions were better understood, it appeared that it would be difficult to improve the effectiveness of public health service counseling programs. Because many related social problems and demands for medical services and facilities are affected by population size, I believed that the results of research contributing to a better understanding of the human values affecting sexual and reproductive decisions could have a broad range of potential usefulness.

The goal I specified in my application for the fellowship was that when my course work and study was completed, "I should be able to design a research project which would:

1. investigate and describe methods of counseling adolescents about family planning in metropolitan Houston;
2. allow an analysis of the rhetorical, psychological, and sociological factors involved;

3. evaluate the aims, methods, and effectiveness of these practices on the basis of the issues involved;

4. yield recommendations about counseling practices and programs."

I believed that a person sensitive to language usage could be valuable in the discovery of influential factors in attitude change both in order to analyze the values implicit in the comments of the women involved in the study and in order to plan improved counseling techniques. I expected to take four courses, each lasting one quarter, and one semester course at three different colleges in the medical center area in Houston in order to gain background in attitude measurement, demographic methods, and adolescent psychology. As I acquired a better idea of the skills needed for general competence in the area of family planning research, I decided to expand and alter my course schedule. I took courses in: demography, epidemiology, experimental design, communications research in public health, communications methods for public health workers, differential fertility of sub-groups in the United States, attitude change and social psychology, independent study in fertility research and biometrics, and (inexplicably) organic chemistry.

In my exploration of the application of my own abilities in this new field, I strayed into such unforeseen projects as writing and producing a radio show on vasectomy and making a film for well-baby clinics on "How to Tell If Your Baby Is Sick." A list of opportunities for applying literary and communications skills and pressing communications problems in health care delivery accumulated throughout the fellowship, providing a ready list for my own future work and the basis for an article on opportunities in the field.

As a result of my study I now have a much better understanding of the problems involved in identifying the influential factors in attitudes toward desired family size and in designing procedures for measuring these factors. A single study will not achieve all that I anticipated in my four-point description of the project I had hoped to undertake. Nonetheless my objectives have not altered, although my strategies have become diverse and I have several plans to announce.

First, I will participate during the summer of 1974 in the construction and pre-testing of an instrument for investigating attitudes toward family planning and the relative value and utility of children to Mexican-Americans living in the Rio Grande Valley. The project will be under the direction of Dr. Benjamin Bradshaw of the University of Texas School of Public Health.

Second, I will also participate in the writing and preparation of media spots to be used in a study of the motivational effectiveness of listener-specific radio and television spots for vasectomy, and the use of birth control by sexually active teenagers in Houston. This project will be under the direction of Winfield Best of the Carolina Population Center.

Third, in regard to my own project, I am now preparing the protocol for an evaluation of counselor-client relationships in the family planning units of the Houston public health clinics. I have been interviewing and consulting for several weeks the appropriate members of the city health department (including, for example, the director of health education, the director of nurse training for the family planning project, the physician in charge of all family planning clinics, the director of social work and counseling, and the chief of nursing) in order to make the study as useful as possible to all concerned. A midsummer or early fall starting date for the project is planned in order to include the new birth control clinic for teenagers (due to open this summer) in the project.

There are also unanticipated results of the fellowship to report. As the months passed, I became interested in the ways human values were inculcated in the classes I attended. My earlier interest in the function of literary study and role-playing was stimulated once more as I observed my fellow students and the effects of the training we were receiving. This interest was intensified by my conversations with Larry Churchill, Walter Vesper, and Les Chard at the conference of Institute fellows in Philadelphia in March. Subsequent conversation with Joanne Trautmann from the Hershey Medical Center gave direction to this interest. I now seem to be progressing toward a theoretical position about value formation in health care education and a rationale for literary study in that process. A second outcome is the desire to interest some of the other fellows and Society members in forming a small sub-group concerned with the function of literary study in medical education. This group would concern itself with course descriptions, bibliographies, theoretical positions, and examples of literary medical scholarship.

During the past months I have undergone a small metamorphosis. After talking with other fellows of the Institute, I feel my experience was not uncommon and will dare to generalize from it--in any case, the other reports can be consulted easily to evaluate my conclusions. We changed, but we did not switch disciplines. I did not awake to find myself a scientist or a social scientist, or even a "health care professional." I am a literature and language scholar still: Bob Martinez remains a geneticist, not a philosophy professor. We retained our identity even when we found it necessary to grasp and employ the techniques of other disciplines.

We emerged to find ourselves dedicated to the cultivation of the intellect, imagination, and sensibilities for the perception and analysis of human value issues. The Institute fellowships were strikingly different from our previous graduate study, in which we plunged deeper into the conceptual complexities and methods of our particular disciplines. During these fellowships we learned to see the possibilities of our various disciplines in relation to other disciplines, institutions, and health care generally, and in discovering these elements and limits and modes of relationship we learned more surely the power of what we were already trained to do.

There seems to have been a catalyst that governed the metamorphosis, making it what it was. To describe that catalyst it may be helpful to recall Cicero's concept of humanitas. For Cicero humanitas signified the qualities, feelings, and needs proper to mankind, not just in a descriptive but in a normative sense--what, being human, we should know and feel about ourselves and our fellow men--the basis of all virtues and just institutions. In our respective studies, a lively awareness of humanitas seems to have been an integral part, even though our investigations pursued such remote matters as medieval philosopher-physicians and legal definitions of insanity. In my experience, it led to a consideration of the human values involved in the application and function of my own discipline in medical education, improvement of health care delivery, and research in population studies and family planning. How can a study of drama and roles shape a physician's understanding of his relation to his patients? How can one improve doctor-patient communication? How can literary skills be used to interpret a woman's response to discover the values she associates with a particular family size? These are broad questions (implying thousands of more specific ones) about the potential of a discipline, but also about its relatedness and functions. I hope that many other scholars will have the opportunity to enjoy the fellowship experience and emerge as "new professionals at the interface of the humanities and medicine." It is an exciting if precarious place to be.

MATTIE L. HUMPHREY

A native of Philadelphia, Mattie L. Humphrey began her professional career with the U.S. Cadet Nurse Corps in 1945. After her training at Bellevue Hospital in New York City, she worked in staff nursing while earning a B.S. in Nursing from Catholic University, Washington, D.C. This degree was awarded in 1953. She then worked as head nurse and supervisor in a large general hospital in the District of Columbia. Her next position was that of nurse-consultant in a small southern city, after which she worked at the City Hospital of Detroit. There she completed requirements for an M.A. in Hospital Administration from the University of Michigan School of Business Administration. Her thesis was entitled "Length of Patient Stay in a County General Hospital."

From 1959 until the present time, Mrs. Humphrey has worked in a range of capacities on both a full-time and consultant basis. These activities have been characterized by a minimum of hospital administration and a maximum of manpower development. Her first community work occurred in Philadelphia where she served as employment coordinator for a vocational program for disadvantaged youth. From this experience she learned that her future priority would be to seek more sensible relations within human services, including education, medicine, nursing, social work, psychology, and law.

Mrs. Humphrey strongly believes that these areas have been dragged too far into the hierarchical forms which characterize industries whose personnel work largely on non-living objects. She contends that in order to establish a value for the quality of the human life of each person who uses human-service systems, vigorous attention must be given to finding, measuring, and understanding the human sensitivity of people to the feelings, needs, and often non-verbalized incidents of violation to the human spirit. This is especially crucial in situations in which individuals have submitted themselves into the hands of professionals out of dependency, fear, need, impotence, or some other kind of crisis event.

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DEVELOPMENT OF THE CONCEPT OF THE "SENSITIVITY QUOTIENT"

Submitted by

Mattie L. Humphrey, R.N., M.H.A.

The purpose of my fellowship was to begin to document the presence of a definable factor, a "sensitivity quotient," as an essential quality for effective nursing service to people. My plan included presenting the resulting data in a way that would have meaning for other workers with whom nurses share health care functions in the course of providing essential health services.

I defined "sensitivity quotient" as the capacity to comprehend and respond to the felt (sometimes feared) deficits in the human condition as an individual experience; and further, as a universal experience available to members of our species through time.

In my view, present practices in our society have downgraded the sentient capacity of Homo sapiens, while exaggerating the powers of rational function. This is especially significant in the health care system. In many cases the culture seems to desensitize the idealism out of our young people as a prerequisite to higher education. Yet this very quality is increasingly being sought by persons engaged in the healing arts and sciences, as well as in the modern helping professions. It is a continuing responsibility to study, communicate, and otherwise project the human value of our sensitivity.

Keeping in mind my intention of focusing on the nursing profession, I developed a tentative survey that would elicit aspects of an individual's self-image in relation to the practice of nursing. It covered three aspects: attitude toward (or expectations of) the nurse as (1) health worker, (2) professional person, and (3) citizen.

Although I was unable to arrange for groups of student nurses, nurses, or secondary school students to complete the survey, the survey as drafted will be used by the Urban Self-Study Institute as an inventory or profile of participants engaged in a prescribed course of self-study. A series of such courses is being designed by the Institute to establish a health planning attitude among non-sick people for the purpose of incorporating human values into popular ideas and expectations regarding health care and delivery systems.

Eventually the proposed survey will be undertaken by three groups:

1. The founders of the Urban Self-Study Institute will use it as a baseline to begin developing curriculum content for seminars in the care and nurture of high-risk members of the population, such as children, adolescents, the incarcerated, the mentally retarded, and the mentally ill.

2. The residents and staff of a half-way house for women recovering from alcoholism will use the survey in conjunction with a course in "Health and Human Values," a creative concept for female heads of households. The survey will help examine the commonality of attitudes within the group toward nurses and nursing.

   The members of this group originally expressed an interest in nurses training; in time this interest evolved into a generalized concern for their re-entry into society after having been segregated out as alcoholics. These women are anxious about their ability to compensate for lost time, money, and interrupted relationships with children and other family members.

3. A Germantown Health Committee which is concerned with monitoring the environment of prenatals and the newborn will use the survey to examine their initial attitudes and expectations about nurses in relation to the actual institutional experience of care during pregnancy, childbirth, and the neonatal period.

I am aware that my subject--the sensitivity quotient, a suggested indicator of the quality of human values as projected by individual persons--is still far from clear definition or even outline. Originally, I saw the sensitivity quotient (S.Q.) as a companion to the intelligence quotient (I.Q.) I felt that it occurred naturally in people, and simply required cultivation and recognition during the formative years.

But recently I have come to sense the S.Q. as a juncture of horizontal and vertical growth patterns which trigger an intense energy response of identification under certain circumstances. Perhaps a human being develops a vibratory spectrum of consciousness which facilitates effective feeling (an interface perception?) with other human beings involved in a comparable experience of emotional depth, such as trauma, pain, loss, stress, grief, sickness, etc.

Formerly, the quality of the S.Q. suggested to me intuitive functions based in the human compulsion to nurture one's life as supplement to the human compulsion to control one's environment. Viewed in this way, it seems more natural to females, subservients, non-intellectuals, and people in the supportive roles of our culture.

At this time, the quality seems to be available in all human beings who experience powerlessness (relative social impotence) as a conscious and paramount burden. For example, some nurses, women, and others to whom I have presented this concept easily rejected the idea that they are naturally more sensitive to the feelings of other people. Yet others identified with the suggested concept, and easily accepted the probability that a nurturing response is their natural tendency. The former (those who rejected my thesis) tended to be those who were upwardly mobile, "revolutionary," and/or competitive, according to the standards set by and for men in our culture. The latter attitude tended to be expressed by those who were stabilized at stereotyped places in the culture. Did their response reflect their manifest condition, or had they created particular conditions out of their vulnerability and "surrender" tendencies?

My own understanding has developed and changed somewhat. It has moved from the concept that certain people are categorically more sensitive to human values (and related deficits that cause suffering), to the suspicion that people develop the S.Q. through being bi-cultural, interface, peripheral, and/or interdisciplinary in their regular daily activities.

In light of the above, I am trying to find ways of examining the common-sense attitude (e.g., similarity of expectations and motivations relative to one set of symbols) held by a variety of people. I would then compare results, not according to particular age, occupation, economic, or sex factors, but according to the variety of dual and multiple traits claimed by the individuals. Do they speak two or more languages, live or work in more than one location or institution, excel in more than one talent, hobby, sport?

This direction is supported by a look at current transitions in the professions which seem to be shifting from explicit knowledge bases to interface systems of data. For example: "medicine and religion," "health care and the law," "social work and psychiatry," "communications and public relations." Can't we consider that the unusually sensitive professional specialists are pioneering in joint data-examination and interpretation? Isn't this leading to new fields?

And is our whole culture subject to a related experience, more or less? Aren't people breaking out of inherited stereotypes and creating affinities with different others, even polar opposites, to a degree greater than a generation ago? Doesn't this imply that some human value is actually stronger than the apparent social, cultural, economic, or material value which is being defied--i.e., changed? Doesn't this raise possibilities for examining the health or quality of life impact which characterizes specialists in the humanities, and making a comparison with their peers in other disciplines? Do they experience the same suicide rate as psychiatrists? If not, why not? Do they experience the same residential mobility as corporate elites, successful business types? If not, then why? Do they present significantly more double-talented career histories than other specialists? Are they more apt to be found in healthy, harmonious situations than are social workers and lawyers? Are they more or less stable in their attitudes and expectations (generally) than are physicians and other health professionals? Are they finding more common interests with health professionals than in previous years? If so, why?

Are there additional possibilities for the humanities and the health professions to enrich each other? The humanities professions function largely as interpreters of, to, and through the culture itself. Thus, the helping and serving professions stand in great need of reassessment about the culture, its basic tenets, its prevailing propensities, its myriad internal schisms, resolutions, and visions. It seems that the commercial interpreters of the state of the culture do so in stereotypical fashion so as not to suggest judgment, criticism, or weakness on the part of persons who are in some position to project negative economic effects upon the particular medium. (This greatly hampers the humanities professions as they attempt to inform and vitalize the culture through its educational systems, especially its public broadcasting systems.)

I feel it would be very useful to involve humanities professionals, health professionals, and information specialists knowledgeable about particular cultural high-risk groups to convene for purposes of improving the flow of authentic and verifiable vital information. This would give the population that needs service some different perceptions of the possibilities for health and healing. This might greatly augment the preventive aspects of health delivery.

My personal professional plans at this time are to fashion a career oriented toward health planning. The foundation for this is nursing--a three-year hospital course followed by a B.S. in Nursing, and supplemented by a Master's in Hospital Administration.

The activities of my Fellowship in Human Values and Medicine have greatly influenced my career development. The concentrated energy required to handle my chosen topic has enabled me to recognize the many different meanings health has for people in my association both on and off the job. Many think only of disease when the word health is mentioned. Few people seem to internalize the gift or habit or practice of HEALTH as something of value lodged in their own being. Yet it is in this subjective tone that I have perceived health as a human value. For many it is a market factor--that is, they cite the "health" of the economic system as an indicator of human health.

I am now concerned with projecting as much as possible those definitions of health which call for each individual to be self-nurturing and self-healing at all times. This would upgrade the manner in which people can understand and cooperate with helping professionals in times of need and dependency. It would also begin to support the heroic efforts of scattered humanists and professionals in the humanities as they seek to raise the standards and norms of popular behavior and personnel practices related to interpersonal relations.

Some specific activities I plan to pursue in the near future are described below.

Education

I have secured opportunities to work with parents to develop teaching materials for pre-schoolers, stressing the practice of health in interpersonal relations in the home, community, school, church, and other environments.

Personal Growth

I have joined a group of female heads of households whose members include several health professionals plus individuals involved in photography, journalism, and other creative ventures. Our purpose is to understand better what makes us value harmony and inner peace, and how we can be instrumental in up-grading these qualities in our immediate environment.

Community Planning

Through the Human Services Cooperative, I have proposed "A Northwest Consortium for the Communication of Vital Information." Its purpose is to bring together the hardware systems (industry, technology, science specialists) and the software (ideas, people, attitudes, habits, visions, aspirations) related to on-going health and social services. This coming together would be for the furtherance of understanding, the mutuality of general interest, and the up-grading of social services (especially health care) to the people of the Northwest, a geographical section of Philadelphia County which is in many ways the hub of the Delaware Valley Region.

Research in Video-Journalism

I would like to study the use of video-journalism to examine human values in health through documenting attitudes, expectations, and habits of a group of working health professionals and the population which they are organized to serve. I strongly believe that "manpower is the message": that health professionals are or are not healthy models and living human examples for those whom they serve, as well as for their students whose minds they mold.

I would like also to investigate through video-journalism the level of verifiable information present in members of the mass culture--an audio-visual search for the evolving human values in mass urban communities. My basic assumptions include the notion that the norms of human values are pervasive throughout the population, even when they are subdued in the so-called "leadership" at civic, political, academic, and intellectual levels of the culture. This study is intended to provide a reference system for defining the flow pattern of particular information from selected focal points of a community to the most peripheral members of that community (plus other useful insights into modern urban life).

During the period of my fellowship, I wrote or began to develop the following papers:

"Effective Planning to Health the Nation: Part II - A New Volunteerism"

This unpublished paper was written for HEW Region III, Office of Civil Rights. The staff of this agency requested the paper, and indicated that they might duplicate it for circulation among the representatives of the five states in Region III, plus the District of Columbia.

The paper stresses that essential volunteerism must be founded upon idealism and human values rather than upon simple material gains and local popularity.

"Human Value Issues Underlying the Crisis in Black Nursing Homes in Philadelphia, Pennsylvania"

This was submitted as an overview of the report of the Interagency Conference for Black Nursing Homes, HEW Region III.

"Our Sensitivity Quotient, or Health in the Urban Culture"

This brochure prepared for general distribution offers some definitions of health, clues to the healthy community, and comments about volunteer activities aimed at acting out human values in relation to crowded urban communities. The brochure also includes a sketch of my involvement in health and human values through domestic as well as employment practices.

"A Guide to Community in the Urban Culture"

I am developing this monograph about how to stay healthy through personal relationships, attitudes, and habits while residing in mass areas (crowded communities). Although this was requested by a publishing company, there has been no action on it since November, 1973. In any case, I will complete it soon, and identify it as related to my Fellowship in Human Values and Medicine.

MARC N. MANGER

Currently a student at the Tufts University School of Medicine, Marc Manger was graduated in 1971 from Yale University where he majored jointly in biology and art history. His career interests include pediatrics, social medicine and mental health, and international health.

He has spent summers working at a remote clinic on the Navajo Indian Reservation, doing a study of health services for runaways and "street children" for the Massachusetts Department of Public Health, and working with the Office of Science Education Improvement of UNESCO, Paris, France.

Mr. Manger is concerned that current processes of pre-medical and especially of medical education are immensely destructive of the humanity, creativity, and personhood of students and future physicians.

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ATTITUDES, FEELINGS, AND HUMAN VALUES
IN THE EDUCATION OF THE MEDICAL STUDENT

Submitted by

Marc N. Manger, B.A.
Medical Class of 1975

Sketching in the Background

> "Would you tell me, please, which way I ought to go from here?"
>
> "That depends a good deal on where you want to get to," said the Cat.
>
> ---Alice's Adventures in Wonderland

Any attempt at ameliorating medical education and the psychosocial environment in which it takes place must necessarily consider the goals of that education, the impediments to the attainment of those goals, and the solutions which might be tried to remove those impediments and reach those goals.

One might feel that a consensus exists with respect to goals, impediments, and solutions in medical education. The similarities between and the modular proliferation of American medical schools are striking. One might feel that whatever issues may exist will be resolved, and goals will be reached, through a process of gradual evolution (rather than Flexnarian revolution) of medical education. But, except superficially, there seems to be no consensus--neither within nor without the walls of centers of medical education and practice.

What relevance has the supply of doctors-as-currently trained to present, let alone future, comprehensive quality health care? The answers are not yet in; within medical education, the questions are not often asked. We have a situation in which medical schools narrowly evaluate the performance of their students as students, but do not evaluate the end results of medical education--the quality of health care actually provided. In such a situation, it is not surprising that so many experts can so disagree, that some can say we face a doctor shortage, that others predict a surplus, and that still others maintain that, by itself, the number of doctors is irrelevant to comprehensive quality health care in our society.

Can we discuss quality health care as a goal of medical education and practice when in fact we cannot yet agree--except at a skeletal, non-comprehensive level--what "quality" and "health care" mean? What concepts of health and illness, of human rights and values, what types of health care personnel and delivery systems, are or will be needed to flesh out the skeleton? The World Health Organization has defined health as a "state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity." True, given such a comprehensive standard, it is hard to imagine much of mankind ever coming near to such a goal. But the goal does give us a perspective on where to direct our strivings: toward a comprehensive well-being which does not concentrate on the physical to the exclusion of the psycho-social. The comprehensive definition, when applied to our own society, underlines how American medical education and practice have been skewed toward treating physical illness, skewed away from dealing with health maintenance and with root causes of mental and social disease.

What are, what should be, the goals of medical education? And what are the actual results of medical education as it exists today? It seems to me that medical schools, with the formidable inertia and stagnation of all aging forms and institutions, have masterfully sidestepped these questions in recent years. Like dinosaurs, they can look back with pride to a long heritage of elucidating and intervening in certain disease processes. But can they, will they, now or ever, evaluate their total performance and output--either as related to their (often forgotten) stated goals, or as related to new (some not-so-new) and emerging challenges? How much longer can medical schools afford to continue ignoring the political, economic, social, and human value aspects of health and of health care organization and delivery? Can "medical education" as it exists in our society avoid de-humanizing physicians and those they teach and treat?

The Fellowship Period

In the spring of 1973, after working for several months with the Tufts University special committee for the creation of a university-wide "Program of Values and Ethics in Human Health and Disease," I decided to apply for an Institute Fellowship to support my part-time work in several areas.

For some time, I have been interested in exploring ways of facilitating an integration of psychological, socio-political, and spiritual awareness in medical education and practice. In my fellowship application, I expressed some of my concerns:

> It seems to me that, in the process of conventional medical education, medical students are progressively dehumanized. I believe that this trend cannot be changed simply by manipulations of blocks of curriculum. I see an urgent need for real qualitative changes, with attention to a fuller range of attitudes and concerns of humane education and human values. Simple quantitative changes in curriculum cannot deal with the deficiencies of an educational environment which dulls human sensitivity and creativity and individuality, an environment which often fails to further (or is even deleterious to) educational and personal growth, an environment which looks at its faults and rationalizes them as virtues or as necessities.

After a summer clerkship in medicine on the Navajo Indian Reservation in Arizona, I returned to Boston to begin the 1973-74 academic year and my period as a Fellow. I was surprised to learn that (for a variety of academic political reasons which I will not discuss here) the university-wide Committee had been, quite unexpectedly, ordered disbanded. The Committee has lived on, in name, at the medical school; but its membership no longer includes university-wide representatives; and its foci have changed to the medical school curriculum and milieu which remain in isolation from the rest of Tufts University (and, one might justifiably say, from the rest of Boston).

Of course, change in academia is no simple exercise. I remain optimistic that the educational environment in our medical school will be ameliorated with time. During my Fellowship period, my own efforts directed toward affecting productive change have included the following:

1.a. Continued work with the medical school's Committee for a Program on Values and Ethics in Human Health and Disease.

b. Participation in an elective course conducted by the Committee for first and second-year medical students, entitled "Moral Decision-Making in the Doctor-Patient Relationship."

2. Consultation with advisors in Boston, Berkeley, and Ann Arbor.

3. Planning of a "Medical Students' Survival Guide" to fill a clearly-expressed felt need of Tufts medical students for information on:

    a. Elective, volunteer, and clerkship/employment opportunities in the United States and abroad.

    b. The "medical school experience"--what it is "really" like (as opposed to what is depicted in official Tufts public relations publications) in the different years of medical training--considerations related to career planning.

c. How previous students have educated themselves about important areas related to health (such as nutrition, drug abuse, health care politics and organization and delivery, cross-cultural study of health and illness and perceptions of the same, folk medicine, etc.)--areas which are not included in the medical school curriculum.

4. Planning of a questionnaire to document, concretely, already-identified felt student needs (and to find new ones) to provide a data base for fostering and focusing formal/informal committee discussions.

We (members of the Committee and of the student council) are planning the questionnaire as a peer-administered (rather than return-by-mail) survey of a random sample of students in all four academic years.

We see this as an urgent prerequisite for affecting meaningful change in our curriculum and educational environment. Having been president of my first-year medical class, I have first-hand knowledge of having worked with "the system," and gotten reforms unanimously passed by faculty committee only to have these same improvements pigeonholed by their administrators who maintain that they see "no problems" in the academic environment. We see a data base as the only weapon on which we can rely in the face of such intransigence, in an environment which provides maximal stresses inhibiting and minimal supports promoting learning and personal growth.

It is difficult for me to speculate what form my involvement will take during the next few years with respect to innovation in medical education. This Institute Fellowship has enabled me to take time to deal with certain issues, identify certain resources and make them known to my colleagues, and plan certain projects which I have alluded to above and which I plan to continue with. I am very grateful for these opportunities afforded me by this Fellowship.

WALTER G. VESPER

Considering himself primarily a teacher and a facilitator, Mr. Vesper has been developing a new program in human values and biomedical ethics at Meharry Medical College in Nashville, Tennessee. Working in a predominantly black medical school, his emphasis has been on informal, "hands-on" teaching of human values and medical ethics on wards and in the day-to-day experience of medical students and house-staff.

After undergraduate training in philosophy and theology leading to the Master of Divinity degree from Drew University, Mr. Vesper became a health educator in the Neighborhood Health Center of Meharry Medical College. "Preparing health education materials for persons of another culture opened up to me the world of human values and medical education, areas I had never known before," says Mr. Vesper. Becoming aware of the conflicting allegiances in the health field and the unwillingness to resolve these conflicts became the impetus to learn more about the world of medicine as well as that of the humanist.

In order to gain skills in the medical world, Mr. Vesper took a position in the newly developing Department of Family and Community Health at Meharry. During this time he developed skills in prenatal education, preventive medicine, and family practice. Along the way he was drafted to write departmental grants (with a 5-for-5 approval score so far!)

Consistently receiving high marks by students and outside evaluators for his contributions to the department's curriculum in biomedical ethics, Mr. Vesper was appointed to coordinate Meharry's Program in Human Values and Biomedical Ethics. Following attendance at the Dartmouth Seminar in Bioethics (conducted by the Institute for Society, Ethics, and the Life Sciences), he accelerated Meharry's funding in human values and proposed the beginning of a school-wide program. Already at the stage of developing school-wide goals for human values teaching, the program will emphasize existing medical school concerns in social ethics as well as medical history, medical jurisprudence, death and dying, and human sexuality.

Mr. Vesper's fellowship experience at the University of Texas Medical Branch left him anxious to extend to Meharry the concept of clinical teaching of human values on the wards.

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OBSERVATIONS ON THE LEARNING AND TRANSMISSION OF VALUES IN A CLINICAL CONTEXT

Submitted by

Walter G. Vesper, M.Div.

During my four-year tenure in the Department of Family and Community Health at Meharry Medical College, I have become aware of many differences in approach to issues of human values teaching between myself and the physicians I meet in the Meharry medical setting. This fellowship represented an attempt to examine these differences as well as to investigate some of the ways that values are transmitted within the clinical setting.

Goals

Major Goal:

> To gain an appreciation for the process through which a physician develops and communicates "medical" values.

Minor Goals:

> To develop a reservoir of experiences in a medical setting based on my own experience rather than the experiences of others.
>
> To produce a series of teaching cases based on first-hand experience.
>
> To work in a program which consciously relates medical practice with the history and philosophy of medicine.

Method

For a period of eight weeks I became immersed in the clinical life of physicians, medical students, and staff at the University of Texas Medical Branch in Galveston. The fellowship period was divided into three periods of about two or three weeks each. My plan for accomplishing my goals took two forms: 1) I wanted to observe the interactions between students and physicians which had particular value characteristics, and 2) I wanted to be aware of the value changes I experienced during my tenure. To do this I devised a series of clinical experiences during which I recorded in a diary those interactions which I felt to be particularly demonstrative of the value issues arising during day-to-day education and service. In the same diary, I recorded my own feelings about the medical system, about the cases I experienced, and about the methods I saw being used to teach (or communicate) particular values to medical students and junior house-staff.

Under the supervision of Chester Burns, M.D., Ph.D., and with the cooperation of H. Tristram Engelhardt, Jr., Ph.D., M.D. many contacts were made with clinical departments within the UTMB Medical Center. The typical pattern would be to explain my goals to the Department Chairperson after having been introduced by Dr. Burns. I would ask to accompany an intern or resident on his (or her) regular daily schedule. Every such request made to a UTMB staff member was met with openness, cooperation, and a general helpfulness which made my fellowship experience one of the high points of my adult life.

An attempt was made to experience some of the physical and emotional influences on the values of a physician-to-be, as well as the more easily investigated conversations about "value" issues. For example, if an intern was scheduled to remain on duty for a period of thirty hours, I made it a point to stick with him (or her) for the entire thirty-hour period. I felt that the influence of fatigue must have a great effect on the values such a person has towards himself or towards a patient.

Similarly, I felt that participation in many of the non-medical experiences of the intern would help me understand the process of value communication used within the medical setting. For example, if the intern went out into the hall to flirt with a nurse, I would be on his shoulder. If he released his frustrations on Friday afternoon by drinking beer, I would be present. In short, my method of appreciating the process through which a student physician learns values, was to imitate to the best of my ability the life-style of a particular intern or resident. To approximate the physician's responsibility, I developed my own diagnosis and treatment plan for each patient.

Varying amounts of time were spent in the Department of Family Practice, the Emergency Department, the Departments of Medicine, Surgery, Psychiatry, Obstetrics, Pediatrics, and Neurosurgery. Additional experience was gained in the Shrine Burn Center, in a regular weekly rounds of the pediatric hematologists, and in the Hospital Chaplain's office. Consistently, I sat in on patient interviews and examinations, being asked on more than one occasion to participate in interviewing, diagnosis, or treatment. I was often asked in the Emergency Department to lend a hand during a "crash case" or to comfort relatives or patients undergoing grief or other crises. I regularly contributed to case conferences in Family Practice and Pediatrics.

I viewed the fellowship experience as a once-in-a-lifetime opportunity to be accepted within the guild structure of medicine. Consequently, my major emphasis during the experience was not academic but experiential. It was difficult to ignore the impressive library in medical history and philosophy at UTMB. However, I was rewarded by the unselfish concern and interest of innumerable faculty, students, and staff within the clinical world of the several hospitals and practice units in the Medical Center.

Findings

The expectations which students, house-staff, and faculty had of persons in medical humanities provided an important insight into the medical setting and into their thinking about medical humanities. When I was first introduced on the wards, several reactions were common:

1) One was to say that ethical or value-issues weren't seen very often on their wards. A similar response would be to ask my opinion of euthanasia or a similar problem. I interpreted this as a way of letting me know that they knew something about the field of human values, but considered it foreign to their everyday world.

2) Another common reaction would be to tell me that the values a physician has were there before he even entered medical school. I interpreted this as saying, "I may learn new things in medical school, but I'm still the same person."

3) They might say, "Do you know Dr. Burns or Engelhardt?" (the medical historian and medical philosopher on campus), while bemoaning the fact that they were not able to be in the newly organized freshman class in medical ethics.

4) Or, as happened more often than I would have expected, they would say, "I have this or that ethical problem on the wards. Can we talk about it?"

5) One physician expressed surprise that I was young and could feel comfortable in his field of knowledge. He said that he expected a 65 year-old Englishman in tennis shoes, a baggy suit, with his nose in a book all the time.

Efficiency

To me, the most important finding was that clinical teaching in human values was based on the development of efficiency. Much as the capitalist's major goal is to earn profit, the development of a physician emphasizes efficiency. Anything hindering this efficiency is to be suspected, if not rejected out of hand as "soft." Let me give a few examples:

1) After spending about 40 hours in the Emergency Room, I found myself willing to ignore any patient input that did not immediately contribute to the processing of the patient's acute problems. Unimportant patient input hindered my efficiency. One morning at 6:00 a.m. I found myself extremely angry with one man who would not swallow a

naso-gastric tube. I was not so upset that he would not swallow it, but that he was wasting my time. I wanted to hit him.

2) Aligned with the drive for efficiency was a feeling of needing to protect myself at all costs. I found myself echoing the often heard cliché about wasting ten years of schooling on just one patient. I wanted to take dozens of x-rays of one fat, rich woman who I felt might someday want to sue someone for her injured back.

3) I found that a numbness developed in my sensitivity after working for a long time. It was difficult to be concerned about the alcoholic patient who had been busted up in a fight just twenty minutes after we had lost the struggle to save a young woman injured in an automobile accident. Likewise, it was difficult not to view the psychiatric patient as someone who was keeping me from the patient in the other room who, after all, had a "real" broken arm.

The Reward System

An important tool used for informal value teaching in the clinical setting was the necessity to block out "trivia" from active consideration by the physician. "Trivia" was defined from the standpoint of acute diagnosis and treatment instead of the less glamorous chronic or "soft" problems belonging to the disciplines of psychology or other behavioral sciences. Senior faculty and residents rewarded students for their interest in difficult or "interesting" cases such as a blockage in a liver, while not having much concern for the alcoholism that caused it. Students were rewarded not only for what they did, but for what they did not do. They were rewarded for doing the job and for staying out of trouble. Messiness of any kind was to be avoided. Also to be avoided at all costs was a talking down. To be coveted was a good, quick diagnosis with a clean resolution of the patient's acute problems. Pragmatism became the only way of keeping up with the impossible task of knowing all one needs to know in medicine. Students told me that what they learned in the behavioral science course they took their first two years (where they learned to treat the whole patient) was great -- but just try to use it on the wards. Just see how you get talked down for not getting a "real" diagnosis.

Environment

The physical and social environment of the treatment area seemed crucial in the communication of values to the clinical student. What the preceptor valued appeared most important in the development of student values. I think it goes without saying that a preceptor who valued big cars, country clubs, and the exclusion of "soft" disciplines might affect the values of a student studying under him. Many residents in one department felt that the ideal sport was trap shooting, following the example of a past departmental chairman.

A similar observation may be made about what is valued by whole clinical departments. Some departments tended to be quite concerned about the cost of care and about the participation of patients in the development and planning of a treatment plan. Others ignored the easily correctable underlying causes of acute diseases. One department demanded the rigorous use of terms such as "retarded," while a physician in the Emergency Room was heard to praise the rain falling outside because it would "keep the trash out." Some departments emphasized the differences between what was valued by the physician and what was valued by the patient, while others did not. Students seemed to consider actively only those value issues which appeared to be important to the preceptor.

Non-verbalness

I found that many of the most important value decisions were raised or communicated non-verbally or through the use of codes. For example, the decisions to terminate an attempt to resuscitate a patient with a severe head injury was made by the senior staff member's shrugging his shoulders and turning away. The rest of the team removed the support machines without a word. Other examples include:

1) A student reported that the decision as to whether a person would be put on the "no codes" list (a list of who should be resuscitated) was made by someone's saying, "I think Mr. Jones should be 'no codes.'" He reported that this agreement is made non-verbally.

2) A conversation overheard on a ward stated, "We will treat this child, but mostly we will keep him comfortable." What was really being communicated was that the child was approaching the end of a bout with cancer, and the staff was looking for a "good" way for him to die.

3) Physicians seldom talked of a patient's "dying." Usually the patient "went down the tube," "passed on," or "gorked."

Style

Much of what I found in the clinical setting was not so much the communication of particular information as the development of a style of doing medicine. For the most part, students learned to value what was valued by their preceptor. It was not an accident, for example, that little concern was expressed about the stance toward blacks taken by the house-staff, since there were only two or three black physicians in the medical center. In fact, senior staff were heard to describe patients as "a nigro male" or "those niggers." This occurred in a community where over one-third of the patients are black.

Many staff members were acutely aware of the ethical content of their actions. I overheard several heated discussions about whether to offer AID (artificial insemination, donor) to a childless Catholic couple. Similarly, one resident made a special point of admitting a patient who needed a D&C on a Thursday night so that the woman would only miss one day of work. Other staff members discussed whether they should offer an abortion to a pregnant woman with four children and a newly diagnosed serious case of rheumatic fever.

Discussion

The fellowship experience at the University of Texas Medical Branch provided me with the opportunity to feel as well as read about the ethical and human values issues taking place in a large medical center. The hands-on experience has made my teaching at Meharry more believable and, I believe, of a higher quality.

It has been easier for me to see where some of the characteristics which patients like and dislike in physicians come from. Though no solutions to the major problems seen in the teaching of human values have emerged, at least some areas for future study have become apparent. For example, would intervention with senior faculty be more productive than with freshman students? Would it be possible to measure some of the characteristics of a preceptor that a school would like to reproduce (i.e., concern for the ethnic background of the patient) and reward faculty behavior in this area? Would the values expressed in the Texas Medical Center be reproduced in other locations?

In short, the experience of the Institute Fellowship has opened a world of experience and possible directions to me.

STUDIES OF ETHICAL ISSUES

TEODORO F. DAGI

Teo Dagi has long felt that medicine was an essential part of a liberal arts education. He majored in Renaissance Studies at Columbia College, and followed up his interest in the Florentine Neoplatonists by spending several months at the University of Florence as an Italian Government Scholar. During his stay in Florence, Teo was introduced to the restoration of manuscripts in the National Library. He has maintained an interest in calligraphy and manuscript illumination to the present.

Teo received his M.D. from the Johns Hopkins School of Medicine. After his first year, he received a Mendeleyeff Traveling Fellowship to study patterns of health care on the West Bank of the Jordan after the 1967 war. In the fall of his second year, Teo went to the U.S.S.R. to study medical education in the Soviet Union. While he was there, he began a photo-journalistic essay on the life of Soviet Jewry. Parts of the essay have been widely exhibited, and others reprinted to accompany anthropological and sociological studies. During the spring of his junior year, Teo investigated some notions of the normal personality in the Victorian novel under the supervision of the department of psychiatry. This investigation was partially a continuation of the paper presented as part of the requirements for the internal medicine rotation: "Spes Phthiscorum and the Romantics."

Having accelerated and completed his requirements for the M.D. in three years, Teo spent his last year of medical school as a Public Health Service Trainee at the Johns Hopkins School of Hygiene and Public Health. He completed an M.P.H. in international health and medical education, and had occasion to study aspects of the physician-patient relationship in various cultures and at various times with Oswei Temkin and Carl Taylor.

Throughout his medical education, Teo pursued an interest in the mind and in the nervous system parallel to his interest in medicine and the arts. After graduation, he went to the Massachusetts General Hospital as a clinical and research fellow in neurological surgery. Through an experimentally arranged program, he intends to complete his training in neurological surgery and do experimental work in neurophysiology simultaneously. During his first year of training, Teo completed a study of single-unit responses in the cingulate gyrus to hippocampal stimulation in squirrel monkeys using microelectrode techniques. He is continuing in microelectrode physiology, and working in the areas of pain, and in cerebellar stimulation for control of temporal lobe seizures.

In extension of his interest in medical humanities and some rather experimental areas of neurosciences, Teo decided to devote some time to formal study of medical ethics. As a Fellow of the Institute on Human Values in Medicine, he spent three months studying Arabic at the University of Jerusalem, and studying manuscripts at the National Library in Jerusalem, as described in his report. This period of study was followed by a tenure as a Joseph P. Kennedy Fellow in Medical Ethics at Harvard, which he is now completing. Teo continued to work in physiology while studying medical ethics; on July 1, 1974, he will return to full-time work at the Massachusetts General Hospital. At the same time, he will participate in teaching the neurosciences course at Harvard Medical School, and serve as resident tutor in medicine and premedical advisor at Dunster House, Harvard College.

Teo looks forward to a number of pedagogical efforts over the next several years. He is presently completing an essay on the case study method of approaching medical ethics. At Dunster House, he will teach a seminar on multi-media approaches to concepts of disease, using film, opera, painting, theater, music, poetry, and the novel to study tuberculosis, plague, cholera, cancer, scurvy, abnormal psychology, and several other conditions. Teo is also attempting a small handbook of neurological examination in rhyme. He would welcome any suggestions on these projects, and is open to collaboration and critical review from and with all interested colleagues.

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SELECTED STUDIES IN MEDICAL ETHICS

submitted by
Teodoro F. Dagi, M.D., M.P.H.

My essential desire in requesting a fellowship from the Institute revolved around an opportunity to study Arabic in Jerusalem at the same time that medieval Judaeo-Arabic manuscripts were being researched at the archives of the National Library of the Hebrew University of Jerusalem. My initial expectation was simply to learn the language well enough to address the question of what constituted an ethical decision in the mind of the Jewish medieval physician-philosophers.

As a secondary goal, I hoped to be able to apply the answer to that question to a wider historical and philosophical consideration of the effect of that particular notion of ethical decision on Talmudic codifications and Jewish legal precedent in the post-medieval and renaissance period. As I became more involved, it became clear that the primary and secondary goals each had ramifications far beyond what I had imagined, as I shall discuss below.

My fellowship tenure allowed me to do the following:

1. Take an intensive five-hour per day course in classical Arabic, so that I can now read the language with some facility, and extrapolate from classical Arabic to the various Arabic-inspired dialects used in Islamic courts.

2. Review the collection of manuscripts in the National Library, concentrating primarily on the Maimonedean medical glosses and the rabbinical responsa of the gaonic period.

3. Examine the Talmudic approach to the teaching of moral precepts and the relationship of moral to legal in Talmudic codification.

4. Apply specific Talmudic notions of procedural justice to review committees in ethics and hospital policy.

5. Extend the concept of sacred as defined by Durkheim and Malinowski, and as exemplified by medieval anecdotes and Talmudic obiter dicta to a wide variety of phenomena in medical ethics.

I originally envisioned myself doing a primarily historical study which would evoke ethical relationships and pedagogical references. I found that within the material I was studying, an historical approach alone did not suffice. I also found myself reaching the limits of my understanding of the relationship of social science to historiography, and of historical ethical development to medical ethics. As a result, I decided to leave go, somewhat, the depth of the historical investigation I was contemplating, and concentrate more on the application of the material I was reviewing to contemporary practice.

In the course of modifying my original research intentions, I was struck repeatedly by the manner in which the criticisms of medical practice in the past were based not so much on the physician as a professional, but rather on the physician as a moral agent in a society where the concept of morality involved legal sanctions. Furthermore, the concept of medical ethics could not be assigned only to the physician: the moral obligation of the patient relative to his disease was as much a part of the physician's therapeutic concern as the accuracy of his diagnosis and the correctness of his therapeutic regimen. Since the physician was considered a moral agent, it was clear that those who held moral warrant within the society also held authority over the physician's practice.

This sort of relationship between the physician and the patient, the physician and the moral overseer, or the physician and the law as a unified corpus was not in and of itself surprising, except for the fact that the manner of discussion of these matters in medieval times was essentially identical to the manner of discussion of these same problems today. Even the similarity did not appear particularly outstanding were it not for the fact that the adjudication of the moral conflicts we are undergoing at present in medical practice were carefully reviewed at other times as well. The underlying connective pointed me in the direction of religious ethics as a constant source of adjudicatory characteristics in present medical ethics, and the investigation of the religious motifs took me to the classical religious phenomenological literature.

The underlying theme I see arising over both an historical and a contemporary view of medical practice involves the introduction of taboo as a conceptual tool in medical ethics. Within the Talmud, and the body of rabbinical responsa as a whole, the tie between danger, sacredness, and ritual is particularly strong. I discussed some of these characteristics of taboo in relation to medicine in "The Concept of Taboo and the Practice of Medicine" (appended).

From pursuing detailed study of the codifications of the Talmud, I began sensing a difference in logic between the traditional Jewish legal and ethical sources and the essentially Aristotelian logic which secular and Christian sources (through Aquinas) adopted. Unlike the truth-tables of Western logic, the Talmud will admit no proposition unless both the assertion and its inverse can be shown to be true. Functionally, this can be stated as: "if a implies b, then not a must imply not b," and so on in the logical system. This is terribly important because it defines morally reprehensible actions in specific terms of omission and commission: if one is subject to an obligation, one must perform; if not, one is prohibited. In consequence, the moral system which the Talmud appears to be indicating is one which combines a teleological and a deontological system of right-giving characteristics. It specifies only those situations in which it can (logically) make valid statements of the nature indicated. I would like to take this mode of ethical precision further, and apply it to pedagogical tool: teaching this sort of precision to medical students who would be making decisions in their functions as physicians would, I believe, do more for the advancement of medical ethics than a casuist or simple deontological approach. I have begun dealing with these issues in the draft on the "Kitsur Shulchan Aruch."

Finally, I opted to study and consider formally the assumption that committees can do better than individuals in making moral decisions. The paper on ethical review committees represents a first step in what I hope to be a long-term study of the ethical efficacy and procedural justification for committees working as PSRO's, teaching groups, magesterial bodies, or parlementary bodies. This paper is to be included in a symposium on psychosurgery.

To summarize, the detail of my humanistic perspective on medicine has varied somewhat, but my impression that the practice of medicine requires that viewpoint has only strengthened. My impression, however, also indicates that a simple interdisciplinary congress of the various humanistic and medical disciplines will not suffice. The practice of medicine must be accompanied by the practice of humanities - and it is my feeling as a physician that this must be done at both a medical school and postdoctoral level.

Medical Ethics in the _Kitsur Shulchan Aruch_*

by

Teodoro F. Dagi

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* Draft - please do not quote. The final form of this paper will be submitted to the _Hastings Center Report_.

This essay is one of an intended series that will examine two aspects of several sources of Jewish law: the logical basis for their conclusions, and what points of behavior relative to medicine they emphasize.

I. Introduction

In the Jewish legal system, the Talmud and the five books of Moses together make up the primary repository of juridical, ethical, and philosophical commentary. The five books of Moses are traditionally called the written law, and the Talmud the oral law. Not until the time of Rabbi Judah HaNasi (c. 5th century A.D.), when the oral tradition was in danger of being lost under foreign and inimical domination, was the oral law committed to writing and codified in the form now known as the Talmud. There are two main Talmudic texts: the Palestinian and the Babylonian. They are alike in philosophy if somewhat different in textual detail. The great medieval codes of Jewish law were fundamentally codifications of Talmudic law and practice, and contain very few amendments to Talmudic precedent.

The Rabbinic literature which followed the Talmud tended in two directions: (1) the classification and cataloguing of Talmudic principles according to some subject, order, or purpose; (2) the collection of responsa - of answers given by specific rabbis to individual questions which, when viewed *en masse*, established new precedents for subsequent rulings, and often summarized the philosophical opinions of a rabbi or a school of rabbinical thought. The Talmud, however, and the Pentateuch before that, remained and continue to remain the primary sources to which all subsequent endeavours were responsible.

The first arrangement of *Halachic* material[1] from the Talmud's unsystematized collection was called the *Halachot Gedolot* (The Great Laws). It was almost certainly a product of the Babylonian academies of Sura and Pumbedita. According to some authorities, it was compiled by Yehudai Gaon (Yehudawi ben Machman, *Gaon* or genius of Sura, 760-764 A.D.), while others attribute it to Simeon Kayyara (892-942 A.D.) Issac ben Jacob Alfasi (active in Fez, North Africa, between 1030 and 1103 A.D.) composed an abridged form of the Babylonian Talmud, commonly referred to as the RIF (from the initials of *R*abbenu *I*ssac *F*asi, our teacher Issac of Fez). The *Halachot* has the special distinction of summarising rules for determining the halacha (*lex formata ex iure*) from the Talmud.

The writings of Maimonedes represent a truly thorough and scientific codex. Maimonedes (Moses ben Maimon, 1135-1204 A.D.) was a physician, philosopher, and mathematician as well as rabbi, and his *Mishneh Torah* (Second [to the] Torah) reflects the same type of rationalist faith as expressed in the writings of Thomas Aquinas.

The *Arbaah Turim* (The Four Rows, so named after the four rows of precious stones decorating the breast plate of the High Priest), compiled by Jacob, son of Asher ben Yechiel (died in Spain before 1340 A.D.), contains four books: (a) *Tur Orach Chayyim* (The Row of the Path of Life), containing laws relating to prayers, festivals, etc.; (b) *Tur Yoreh Deah* (The Row In Awe of Knowledge), containing laws dealing with the ritual slaughter of animals, dietary codes, mourning, and other items of interest to the leader of a community (intimate knowledge of this book is required for Rabbinic ordination); (c) *Tur Even Haezer* (The Row of the Stone of Salvation) which confronts problems of marriage, divorce, and family matters in general; and (d) *Tur Choshen Mishpat* (The Row of the Breastplate of Judgement), relating to cases of torts, contracts, wages, and civil law. The *Tur* was succeded, some two centuries later, by the *Shulchan Aruch* (Set Table) of Joseph ben Ephraim Caro (born in Spain, 1488, and died in Safed, Palestine in 1575). Caro based the *Shulchan Aruch* on his previous work, *Bet Joseph* (The House of Joseph), which was in turn based directly on the *Tur*. The *Shulchan Aruch* was also divided into four books, with one book corresponding to each section of the *Arbaah Turim*.

Insofar as the European Jewish communities were concerned, the greatness of these works was limited by the authors' failure to incorporate *Ashkenazic* (western European) custom within the discussion of the Sephardic (oriental, Spanish, and North African) tradition in which they were trained. A gloss written by Rabbi Moses ben Yisrael Isserles (born in Poland, c. 1520, and died 1572) took this omission into account, and added the *Mappah* (The Table Cloth) to the *Shulchan Aruch*. This gloss was subsequently incorporated into the text of the *Shulchan Aruch*. Together, the two works became the standard rabbinical reference. Many laymen of that time could make use of the reference as well, and the enlarged codex enjoyed considerable popularity.

By the nineteenth century, the standard of lay Jewish scholarship had declined considerably. One of the attempts to assume the responsibility of educating the layman, providing him with a reasonable reference for the study of Jewish law, produced the *Kitsur Shulchan Aruch* (The Condensed Set Table, hereinafter referred to as the *K.S.A.*) Rabbi Solomon Ganzfried began compiling the *K.S.A.* in 1870.

The second half of the nineteenth century was particularly tumultuous in Jewish history. Various political, nationalist, assimilationist, and religious reform movements combined to weaken the communal structure. The widespread Jewish slaughter during the Cossack uprisings of the seventeenth century, followed by the western Enlightenment and the gradual enfranchisement of the European Jew, the Napoleonic Wars, and the revolutions of 1848, demanded a cultural adaptation to which factious movements responded. In the face of such pressure, the religious pole of Jewish thinking became increasingly conservative in many geographical and conceptual areas.

The K.S.A. was written in a small Hungarian town, where Ganzfried was rabbi. He did not hesitate to espouse a strict interpretation of the Halachah. The K.S.A. is regarded in scholarly circles as neither an acceptable reference nor as a universally desirable pedagogical implement. Nonetheless it remains, in some senses, an accurate reflection of centuries of legal deliberation. The K.S.A. expresses a philosophical position which would of needs be deemed overly simple and overly rigid relative to the Talmud, its commentaries, and its earlier codifications.

If one overlooks some of these deficiencies, and desists from expecting an abbreviated deontological table from within the context of an entire legal tradition, one finds in the K.S.A. a representation of Talmudic tradition which would not be repugnant to more scholarly and more liberal interpretations. The K.S.A. also represents the standard to which great numbers of religious Jewish laymen turn for guidance in perplexing situations.

II. The Format of the K.S.A.

Ganzfried's K.S.A. contains two hundred and twenty-one chapters. Each chapter deals with a specific portion of Jewish tradition, civil law, religious ritual, or communal custom. Each chapter is in turn divided into a number of paragraphs. The K.S.A. begins with a chapter dedicated to "Rules of Conduct Upon Arising in the Morning," and continues with such chapters as "Laws Relating to Benedictions," "Moral Laws," "Laws Concerning Charity," "Benedictions over Soup, Fruit, and Vegetable Extracts," "The Holiness of the Sabbath," "One Who is Critically Ill - Forced to Transgress a Precept," "Honouring Father and Mother," "Damages to Property," "The Sick, the Physician, and the Remedies," and finally "Mourning on a Sabbath or Festival," and "Fasting on the Day of the Anniversary of a Death."

The K.S.A. begins with rules for arising in the morning, and ends with the customs of mourning. All human endeavour is assumed to occur in between, and the relevant laws are arrayed according to when in a man's life the laws obtain. A given principle might be re-iterated in two chapters, while principles that one would expect together are often widely separated (e.g., a dead foetus is considered in the section on Sabbath ritual and in the section on menstrual impurity, while miscarriages in general are discussed in the section on childbirth).

III. Medicine and the K.S.A.

The precepts referable to medicine are widely scattered through the text of the K.S.A. Concepts of personhood are intermingled with faith in Divine Justice (Chapter 60, "Benedictions over Sights in Nature" and

Chapter 61, "The Benediction Hagomel [He who grants redemption])" The chapters discussing fast days (Chapters 124 and 133) also consider the conditions under which a pregnant or nursing woman, or one who is ill, might be freed from the obligation of fasting. As part of their discussion, these chapters also rule on the general relationship between religious and personal obligations and particular states of health.

"Laws Pertaining to Bodily Damages" includes both a principle requiring one to go out of one's way to aid a person in distress (184:8) and a deliberation concerning the point until which an unborn child may be destroyed in utero in order to save the mother (184:12). Sterilization in any form is prohibited in 191:5, "Cruelty to Animals." The prohibition applies to both man and beast.

Finally, there are six chapters dealing with medical matters specifically: Chapter 91, "One who is in Pain, and One not Critically Ill"; Chapter 92, "One who is Critically Ill, and Forced to Transgress a Precept"; Chapter 93, "Concerning Childbirth"; Chapter 192, "The Sick, the Physician, and the Means whereby One is Healed"; Chapter 193, "Visiting the Sick"; and Chapter 194, "A Dying Person and the Death Watch."

Although these chapters contain all the rulings which the K.S.A. propounds in the area of medicine, there exists controversy about many of Ganzfried's decisions. Much of the Talmud's uniqueness arises from the formalized stream of logical consciousness which characterizes the nature and content of its juridical deliberation. Only rarely are these characteristics manifested in the K.S.A. While the source which this paper studies is certainly indicative of Jewish philosophy, it is neither diagnostic of Jewish philosophical deliberation nor conclusive of Talmudic arbitration.

IV. Specific Precedents in the K.S.A.

The closest to a general theory of personhood is found in three paragraphs from the chapter on "Benedictions over sights in Nature":[2]

> On seeing an Ethiopian, a Red Man, an Albino, a freak such as a giant or a dwarf, one whose skin is ulcerated or whose hair is fully matted, or an elephant or an ape, one says: "Blessed art Thou, O Lord our God, King of the Universe, who varies the forms of His creatures." One makes this benediction only at first sight, when the variation is particularly striking. (60:13)
>
> On seeing the lame, the amputee, the blind, the bullous, the scrofulous, the leprous, or those afflicted with white lesions, one says, if the condition was congenital, and if one sees it for the first time: "Blessed art Thou...who varies the forms of His creatures." If they were afflicted after birth, however, and their aspect is grievous upon us, we should rather say: "Blessed art Thou...the Just Judge." (60:14)

> On seeing beautiful trees and lovely creatures, even idolators upon whom we should not purposely gaze, we say: "Blessed art Thou...who hast such as these in His world." This benediction is to be said on first sight, and first sight only, unless succeding visions are even more beautiful (60:15).

The accepted state of the universe is taken to include both pleasant and unpleasant experiences, and both attractive and repugnant sights. A blessing is required even for those who suffer. The nature of the benediction, however, reveals the sympathy with which the Talmud regards the crippled. When suffering is present, but presumably mitigated by the individual's innate inability to imagine himself different, the benediction differs from that applicable to one visited while in possession of a normal body image. Both beauty and deformity are accepted nonetheless: beauty is appreciated for its existence, while deformity is accepted in virtue of the variety it introduces into the world.

Two sections discuss when a foetus becomes a person:

> He who prays for an event that has passed--for example: one who hears an outcry in the town and prays that the outcry be not in his house or whose wife is forty days after conception and prays that his wife might bear a male child--prays in vain, for what has happened is unchangeable. Before forty days have passed, however, such prayer may be of use. After forty days, one may pray for a child who will be viable, good in the eyes of Heaven, and good in the eyes of man (61:6).
>
> When a woman is in the throes of a difficult birth, it is permissible to destroy the child medically or surgically, for, so long as the child has not entered upon the atmosphere of the world, he is not considered a living soul, and one may sacrifice the child to save the mother. This is considered equivalent to the case of seeing one person pursued by another who intends to kill him [and one may kill another in such a case in order to save the pursued]. But from the moment that the head of the foetus protrudes, one may not touch him. One life must not be sacrificed to save another, and this is the nature of the world (184:11).

Another chapter deals with the related question of castration:

> It is forbidden to castrate man, beast, bird, or animal, clean or unclean, in Israel or elsewhere. It is prohibited to cause sterility by means of medication as well. Violators are subject to flagellation (191:5).

Sterlization evokes the strongest condemnation. The foetus enjoys special protection, despite the ambiguity in which the protection is shrouded. Clearly, however, the pregnant woman receives the highest veneration:

> As soon as a woman feels her labour pains beginning, even should she be in doubt, one is obliged to have a midwife brought even if she must travel a great distance (93:1).
>
> A woman in childbirth is considered as one in danger of her life. The Sabbath laws should be disregarded for her sake no matter what she requires.... She is to be considered in childbirth as soon as she is in travail, or as soon as blood begins to flow, or as soon as she is incapable of walking by herself. A woman who miscarries within forty days of conception is considered as one in childbirth (93:2).
>
> A newly born infant is to be washed and separated from the cord. His limbs are to be straightened, and all that he requires should be done. If the infant is not viable at birth, however, being born at eight months, for example, it may not be handled [on the Sabbath]. The mother, however, may bend over to suckle the child, to allay the grief of the milk in her breast (92:5).

One has a strong obligation to go out of one's way to assist someone in distress:

> One who sees his friend in distress is obligated ex misericordia to help him, either by his own efforts or by hiring others. If the one who has been saved can afford it, he must repay the expenditure; even should he be impoverished, one must nonetheless save him at one's own expense, and not shirk one's duty. If one disregards this precept, one is guilty of disregarding the injunction (Leviticus 19:16): "Neither shalt thou stand idly by the blood of thy neighbour." ...and whosoever saves one life in Israel is considered as though he had saved an entire world (184:8).

The generalization of this obligation provides part of the warrant for a physician to practice medicine:

> It is the duty of the expert physician to cure the sick. This duty is part of the general duty to save a life in danger. If he evades this duty, he is guilty of shedding blood; and this holds even if the patient has another physician, for not every man has the virtue of healing -

> and perchance it has been decreed that his patient be cured by his hand. No person, however, shall practice medicine unless he is competent to do so, and unless there exist none greater and more expert than he, lest he be guilty of bloodshed (192:4).
>
> If one has medicaments, and another falls ill, one is prohibited from raising the price thereof unreasonably (192:10).

Not all of the views expressed in the K.S.A. are so rational:

> Rabbi Phineas, son of Chama, preached: "Whosoever has a sick person in his household shall visit a sage and bid him plead for mercy, as it is written (Proverbs 16:14): 'The wrath of a king is as messengers of death, but a wise man will pacify it.'" It is customary to give to charity on behalf of the sick, for repentance, prayer, and charity avert the evil of the decree. It is also customary to bless the sick in the synagogue; and if the patient is critically ill, he may be blessed even on the Sabbath or on a Festival. At times, the name of the patient is changed, for a change of name can also nullify an evil decree (192:2).

The paragraph immediately following returns to a more empirical stance:

> The Torah permits the physician to heal the sick, as it is written (Exodus 21:19): "And he shall cause him to be thoroughly healed." A sick man, therefore, should not rely upon a miracle, but should rather take heed of the world and consult a physician to cure him. Even some of the most pious men in the world have been healed by physicians. And he who hesitates to consult a physician commits two wrongs: one forbidding the reliance on miracles in the face of danger, lest such reliance lead to one's transgressions being remembered; the other in that pride and presumption are manifested in depending on a miraculous cure in return for righteous behaviour. The patient should seek the most competent physician, but he should still turn his heart Heavenwards and place his faith in the Faithful Healer, pleading for mercy, trusting in Him alone (192:3).

Great stock is put in the distinction between those who are critically ill, and those who are not:

> A person who is critically ill may turn to any article for his treatment, even though the enjoyment of that article might be intrinsically prohibited, for, with the exception of idolatry, incest, and murder, nothing shall stand in the way of the saving of a life (192:7).

> A patient not in danger of his life, if he might achieve a cure by means of an article permitted to be used, shall do so, even though some delay might be required.... (192:5)
>
> There are those who maintain that a person may employ, within the course of a cure, some articles bearing a Rabbinical prohibition, even though he might not be critically ill. He may even enjoy the article, so long as he neither eats nor drinks it (192:6).

There is an obligation to visit the sick of all types, critical or not:

> When a man falls ill, it is incumbent upon every man to visit him... (193:1).
>
> The basic reason to visit the sick is to see to their needs and discover what they require. One also prays for mercy on their behalf... One should not visit the sick during the first three hours of the day, for their illness will appear too mild; one will not be moved to pray for him. One should also not visit during the last three hours of the day, for then the sickness takes a turn for the worst, and one despairs of begging mercy (193:3).

Ganzfried included in this chapter (193:1-14, "On Visiting the Sick") rules pertaining to truth-telling and confession. He has this to say about truth-telling to the sick:

> Visitors should speak with the sick using tact and wisdom, and should neither encourage him unduly nor bring him despair. They should encourage him to talk of his affairs, whether to redeem loans or secure pledges; let him not fear that he will hasten his death thereby (193:5).
>
> One should not reveal to the sick who has died and who has not, that his mind might not be disconcerted. Should he become aware of a death, let him not rend his garments in mourning lest his anxiety be increased. One should neither weep nor mourn before the sick lest he fear that he, too, will pass away.... (193:9)

When a person does turn for the worst, however, and death is imminent, one is urged to seek the individual's confession (193:13-14). In contradistinction to some other philosophies, however, the purpose of the confession is to comfort the patient and stimulate his recovery to this life. Illness is not commonly viewed as a tribulation to prepare one for the next life.

The rules governing one's behavior toward the dying are particularly strict in the K.S.A. In this regard, however, Ganzfried was quite in keeping with the spirit of the Talmud itself. One cannot say the same for his conclusions about foetal death and maternal sacrifice:

> A dying person in his agonal moment -- when there is a rattle in his throat from problems in his chest -- is to be...thought of as being living in all matters. For this reason it is forbidden to touch him, lest his death be hastened. Whosoever shall touch him shall be guilty of bloodshed. To what is this comparable? To a candle, flickering, and extinguished by a mere touch. Despite the fact that he might be agonizing a long time, and causing himself and his kinfolk much distress, one may not hasten his death even by removing the pillow beneath his head...(for some people believe that feathers defer death).... (194:1)

The conclusion of this paragraph, however, is nonetheless responsive to the difference between an act causing death by intent, and an act removing an impediment from death's completion:

> Still, if there exists an external cause which prevents the departure of the soul, such as the noise of some pounding, it is permitted to remove this cause, since this act would intend to remove the obstacle without touching the dying patient (194:1).

Even when his agonal moment rules, an individual is considered a person. He must be treated as a responsive and responsible person, and as a member of the Jewish community:

> From the moment an individual is in the throes of death, no one may leave him, so that his soul may not be alone when it departs.... It is proper to get together, ten male adults to be present, at the departure of the soul.... (194:4)

Finally, the K.S.A. defines the diagnosis of death:

> After the departure of the soul, a light feather is placed at his nostril: if it does not move, let it be announced that he is dead.... (194:5)

This definition is not adequate according to Talmudic standards (c.f. Jakobovitz (1959), 126 ff.)[3]

Jewish medical ethics tends to differ from the medical ethics of other philosophies in three ways: (1) there is often a conflict between one's religious obligations and the demands on one's health in illness; (2) Jewish philosophy generally avoids the view that illness in this life prepares one for the next; cure is actively pursued, and a return to normal life given priority; (3) most of the precepts, in the course of their development through rabbinical responsa, were directed at the individual who was sick rather than the physician.

Ganzfried's interest and avowed purpose lay in providing the average member of the Jewish community with a vademecum. It is obviously not as scholarly nor as comprehensive as one would wish, and presents some rather uncomfortable ambiguity on even superficial probing. The K.S.A., however, makes no pretence at developing a deontological formulation: one is given a list of behavioral imperatives and rules for their modifications within circumscribed bounds. The philosophy is written elsewhere.

In the light of other Talmudic sources, some accurate inferences may be drawn from the K.S.A., so long as one does not try to generalize them into a universal Jewish perspective: (1) human life is invaluable, and takes precedence over all other values except where incest, idolatry, or murder is involved; (2) the critically ill are to be considered at all times as though they were at risk of their lives; (3) while suspicion of risk of life suffices to allow transgression of almost any precept in the critically ill, the non-critically ill are judged more severely; (4) a woman in childbirth is to be considered critically ill during a certain time period; (5) there is a tendency to value the life of the mother over the life of the foetus up to a certain point; (6) sterilization is prohibited; (7) one is morally obligated to go out of one's way to aid another human being; (8) a competent physician is therefore permitted and even required to practice medicine and surgery; (9) there is no intrinsic conflict between the practice of religion and the practice of medicine; and (10) a dying person is to be considered alive and functioning within the Jewish community until he has been proven dead.

One must admire the K.S.A. for the straightforwardness with which these principles are set out.

FOOTNOTES

1. Halacha is the technical Hebrew word for the collection of rules which subsume a series of behavioral imperatives. The word is derived from the root h-l-ch: to go (ire), and bears the implication of a path of righteous behavior.

2. Translations by the author from the revised edition of Ganzfried, Rabbi Solomon: Kitzur Shulchan Aruch, New York, 1961

3. Jakobovitz, Rabbi Immanuel: Jewish Medical Ethics, New York, 1967.

The Ethical Tribunal in Medicine*

by

Teodoro F. Dagi

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I. Introduction

The practice of medicine is inexact. Uncertainty accompanies it at every stage of the physician's task. The physician observes the patient and attempts to be as objective as possible, intending not only to benefit that particular patient, but also other physicians who may become involved and other patients whose treatment may be influenced by previous medical experience.

Advances in technology can improve the physician's powers of observation. Stethoscopes might be made more sensitive, for example, or x-ray procedures more revealing. Moreover, the retrieval of available information may be improved through the use of computers, data processing devices, and audio-visual long-range consultation. However, such improvement in the physician's powers of observation and measurement does not necessarily assure the correctness of the ultimate decisions he reaches; the unanswered questions that plague medical science prevent such easy transit from observation to action.

The availability of advanced medical technology in the context of the present limits of medical epistemological certainty has raised serious ethical problems. The possible benefits which might accrue to the patient must be weighed against the possibility of increased suffering, cost, and risk in the development of such technological advances.[1] An extreme example of the quandary is the medical profession's ability to maintain artifically a patient's vital signs and hence keep him technically alive in the face of irreversible loss of consciousness and great suffering to his family. Another example is provided by psychosurgery, the subject of this symposium. It is the purpose of this article to comment on a method of dealing with such ethical problems.

II. The Changing Face of Modern Medicine

The technological developments discussed above have affected the role of the physician in society. One scholar has referred to the evolution of the "physician-friend" into the "physician-scientist."[2] The patient perceives the physician-friend as being primarily concerned with his welfare. The physician-friend often knows the patient intimately, and, at any one point in the physician-patient relationship, can expect a continuation of this relationship with the patient or with his family. The physician-scientist, on the other hand, is much more detached from the patient he treats. His primary allegiance is perceived as being to medicine itself rather than to any particular patient, and he might well be in a position to study one patient in a conscious attempt to benefit another.[3] Such a pattern is characteristic of frankly experimental procedures, but it is also increasingly present as the limits of medical epistemological certainty are approached in everyday practice.

The distribution of medical care has also been affected by this combination of social and technological change.[4] It has become impracticable for every hospital, regardless of size and potential patient population, to own every available instrument or machine. It is equally difficult to find physicians trained in all techniques and procedures involving elaborate equipment. Thus, the large medical centers become even larger as peripheral medical facilities refer cases up the academic ladder. Clearly, then, we have moved away from the personalized treatment of the physician-friend and closer to the depersonalized treatment of the physician-scientist and the institutions which support his work. This change in the face that medicine turns to the public exacerbates the ethical dilemmas within the profession.

III. Approaches to Medical Ethics

Increased awareness and incidence of ethical dilemmas in medicine have produced what may be termed the diagnostic[5] and the curative[6] approaches to the problem. The diagnostic approach is concerned with the recognition of dilemmas in the everyday practice of medicine and in those specialized areas where the correlation between action, knowledge, and certainty is to some extent in doubt. Although the curative approach also recognizes actual and impending quandaries and advocates the constant education of practitioners, it adds to this process of sensitization a demand for decisions on controversies extant.

Both approaches address themselves to three categories of questions as identified by Arthur Dyck: the "normative," the "metaethical," and the strategic."[7] Normative questions are concerned with the rightness and wrongness of actions, persons and states of being. Metaethics studies the process by which moral judgments are pursued and moral debates arbitrated. Strategic questions focus on the realization of what is decided in the course of ethical debate and philosophical disputation.

One often hears, in medical circles, that the best ethical judgment is that developed through years of clinical experience -- the bedside ethical intuition.[8] Proponents of this point of view often note that ethical medicine is based on little more than common sense and consideration.[9] It is true that the physician draws upon a long tradition of medical ethics. Coupled with legal restrictions on the nature of his practice, and hopefully qualified by his essential dedication and classical philanthropy, the physician's tradition is often thought to cover all situations. The physician traditionally has learned to refrain from administering poisons, splitting fees, or performing abortions.[10] He also learns to be constantly aware and consistently abreast of the consequences of his actions.

The standard by which such consequences are to be judged, however, can be identified only imprecisely. It is as difficult to establish as the consequences are to predict. Even if it were once possible to establish valid ethical standards on the basis of human consideration and intuitive understanding alone, the changes in medical practice which have led to the development of the physician-scientist and to a depersonalized system of medical care undermine the validity of ethical judgments made according to such standards. When there are only two possible consequences to a given course of action -- one clearly desirable and the other clearly undesirable -- a rational and ethical judgment is easily made. Medical exigencies, however, are seldom so kind. The physician's decisions are often based on considerations of relative risk. Thus, there is always the possibility that any chosen course of action may ultimately prove erroneous. The care with which the physician decides to adopt a particular therapeutic course surely reflects his sensitivity and medical ability, but the exercise of such care cannot always assure the rectitude of his action.

The cumulative experience of many physicians in practice, and of thoughtful individuals encountering ethical conflicts in their own lives, has supplied a reservoir of cases to be studied. The difficulty with the lingering problems posed by those cases, however, lies in the fact that society generally seems unable to sustain a long-term interest in matters that are incapable of quick resolution. The more tension-bound the nature of the interest demanded, the more likely it is that a psychological equilibrative mechanism of disinterest will develop. This symposium adequately illustrates that the new problems posed in medical ethics may well appear more prominent. It is therefore all the more imperative that an acceptable method of dealing with these problems be established.

IV. Ethical Validity in a Secular World

In many ways, of course, the difficulty in establishing valid ethical standards in medicine parallels the more general ethical difficulties that have resulted from the secularization of human existence. The process of secularization -- the vulgarization of attitudes and behavior previously held in higher esteem -- has advanced as the number of formal values to which people subscribe has diminished.

The various forces that are responsible for this development have also weakened the institutions which teach and uphold these formal values. This is not to say that modern society is possessed of no ethic while the eighteenth century was holy. Nonetheless, it is clear that, apart from religious writers, the twentieth-century moral philosopher is less likely to base his arguments concerning normative moral issues on Divine Right than was his pre-revolutionary French counterpart. The evanescence of society's reliance on religious systems did not, however, resolve its moral dilemmas. The existential questions of a person's function in life, his attitude toward his own body, his interaction with his community, and his allegiance to a well-defined ethical system persist.

In a non-secularized society, the substantive basis for arriving at ethical judgments is predicated on a stable authority residing outside society. The method by which such judgments are reached is in turn founded upon the intrinsic value of previous decisions. In this manner, both the substance and the methodology of the judgments are carefully controlled. Insofar as external authority is no longer uniformly accepted as a universal substrate for ethical imperatives, authority for the correctness of judgments has focused on method.

But the authority of moral imperative and ethical rectitude can only be approximated by procedural or methodological correctness. It should be recalled that a false premise leading to a false conclusion may entail a true proposition. It follows that methodological precision, or "procedural justice,"[11] does not necessarily ensure premissory integrity or "ideal justice."[12] An awareness of the constant possibility of error in judgment, procedure, and behavioral imperative necessitates the establishment of safeguards such as those contemplated by the *Talmud* when it advised the Sanhedrin[13] to "judge all men charitably"[14] and to assume that "each [man] has a share in the world to come."[15] Such concerns overlap the diagnostic and curative distinctions mentioned above, and include the normative and metaethical aspects of Dyck's analysis. To the extent that procedural and ideal validity result in behavioral imperatives, these concerns include the strategic aspect as well. We have notions of right independent of procedure; had we not, procedural justice alone would suffice.

Concern over both the procedural and the ideal have focused on the arbitration of opposing or complementary interests and ideas in an attempt to approximate the valid answer to any particular problem. The instrument of arbitration may be either an individual or a collection of individuals. One might take great pains to describe and enumerate the characteristics of an individual endowed with the wisdom, talent, and expertise to decide correctly any subject under consideration.

In addition to directed omniscience, a sense of justice, pure disinterestedness, and universal philanthropy, such an individual would require social warrant and juridical authority to make such judgments and enforce their concomitant imperatives. Indeed, such an individual would have the characteristics of Plato's Philosopher-King.[16] Modern philosophers have also theorized about the possibility of an individual with ideal characteristics, but their hypotheses are somewhat more limited in scope than those of Plato. Roderick Firth, for example, has persuasively argued that what we mean when we say "X is good" or "X is better than Y" is the following: "If anyone were, in respect of X and Y, fully informed and vividly imaginative, impartial, in a calm frame of mind, and otherwise normal, he would prefer X to Y."[17]

The individual just described may be considered an ideal observer, but he is only ideal in his function qua observer. That is, he is "omniscient with respect to non-ethical facts,"[18] but he is not necessarily an ideal moral observer. Although he differs in this respect from Plato's Philosopher-King, in all other respects he fulfills our expectation of an individual making difficult moral judgments correctly, thereby having the authority to arbitrate various conflicts.

Of course, even this hypothetical individual with somewhat more limited capabilities does not exist. Even were an individual worthy of such confidence and warrant to exist, society is simply not prepared to entrust one man with the authority and responsibility for ethical decision-making. The alternative lies in a tribunal. The Roman tribunes were responsible for defending the lives and property of the plebeians, and were empowered to execute their task not by Capitoline statute but rather by an oath of the plebeians to uphold their sacrosanctitas or inviolability.[19]

The modern tribunal could achieve similar social warrant. In the ideal case, it would become a committee composed of Firth's ideal observers. Each of its members would be worthy of unlimited social confidence on his own merits. However, in the absence of ideal individuals, it is much more likely that an aggregate of well chosen individuals incorporated into a unified body will represent a composite ideal. In other words, the tribunal as a whole can be expected to approximate the ideal observer more readily than a single individual.

Aristotle warned that every assessment of a political venture must take into consideration the potential consequences of any deviation from or "perversion" of its perfect form.[20] The presence of a tribunal helps to assure that whatever the perversive process attacking the integrity of a decision, judgment will still be made under conditions as ideal as possible. Even should there be a pollution of the ideal environment, even should the perverted aggregate approximate the ideal observer less successfully than the perfect form, one is still more likely to be satisfied with decisions resulting from procedural justice in the tribunal than with that issuing from an individual.

All forms of procedural justice must be equipped with the capability of considering evidence at some time in the course of their due process, even if some of them decline to exercise that capability on a regular basis. Because of its potential plurality, the tribunal supplies a more open forum for the presentation of evidence and its incorporation into due process than does the individual. A potential plurality of opinions also permits the expression of a multitude of ideas and leads to the projection of personal and corporate doubt. Finally, the extent to which partisan interests affect political and ethical discourse is diluted by a number of wisely chosen arbiters whose collective sympathies are equally distributed.

The representation of diverse passions, persons, and interests is as necessary to the functioning of a tribunal as omniscient philanthropy is to the hypothetical individual ideal observer. Moreover, one can speak of adequate representation within the tribunal and omniscience in the ideal observer or Philosopher-King in the same manner. Both assure epistemic satisfaction with regard to the limits of knowledge and the presence of whatever knowledge is necessary to be certain of a correct decision.

To summarize: the tribunal perverted in the Aristotelian sense remains a more acceptable decision-making body even when conditions are less than ideal; it provides a more reasonable forum for the presentation of evidence; and it excels at the representation of interested parties, relevant expertise, and principled disinterestedness.

The advantages of such ethical tribunals have been noted by recent attempts to formulate public policies concerning ethical dilemmas.[21] Inasmuch as religious systems were sensitive to the difficulties posed by imperfect human perception of the external criteria of right and wrong, they, too, recognized the advantages of tribunals. Indeed, the Talmud devotes the entire tractate of Sanhedrin to questions of the composition and function of various groups of this nature.[22] Acknowledging, as we must, the inherent limitations in human judgment, it is imperative that we at least optimize the conditions for moral debate in any attempt to resolve socially important issues.

V. The Role of the Ethical Tribunal in Medicine

Even if one is prepared to accept the proposition that tribunals are an inherently superior forum for the resolution of ethical problems, there remains the question of how they are to be composed and how they are to function within the present social pattern of medical practice. Where physicians are proposing the establishment of policy which, while not bearing the authority of moral imperative, would represent thoughtful and thorough deliberation on the part of a significant segment of the medical profession, a tribunal might act as a parliamentary body. Under such a rubric, the procedural justice achieved by the tribunal would serve to assure an adequate and accurate assessment of the attitudes of those convened.

Our hesitancy to declare a parliamentary decision the equivalent of a moral imperative is derived from several considerations, not the least of which is medicine's characteristic uncertainty. But just as political philosophy recognizes the validity of legislative and magisterial activity on the part of a parliamentary group even in the absence of moral backing, we may approve of the tribunal's activity because of its value in approximating the most correct result.

In addition to providing an open forum for the presentation of various advocacy positions, the tribunal itself may occasionally advocate a particular position. When, for example, doubt exists in ethical deliberation, perhaps the tribunal should take a position equivalent to that promoted by the Talmud in the maxim "judge all men charitably."[23] Perhaps it should become an advocate for life when the patient's well-being is directly or indirectly threatened by experiment, therapeutic vigor, or therapeutic reticence resulting from the balancing of further suffering on the part of the patient against continued medical intervention. Similarly, when intellectual or physical infirmities prevent the patient from presenting his own case, the tribunal might consider representing the patient himself.

In general, the tribunal may assure, in its quest for methodological precision, that all unbespoken positions are represented. Finally, the tribunal may advocate an independent criterion for the correct result even though its primary strength lies in its ability to pursue procedural justice. In this manner, ideal justice may also be approximated.

In at least one aspect of medical practice, tribunals of a sort have already been introduced. It has been suggested that peer review groups be established as part of the mechanism by which physicians continue to learn and perfect their skill.[24] They may, for example, serve the function of apprising local practitioners of the nationwide standards to which they must conform under recent court holdings.[25] The education of a physician should not, however, be concerned solely with materia medica, because his practice is guided not only by clinical standards but by ethical standards as well. Therefore, the continuing education of the physician must also include an ethical education. Thus, the tribunal which functions elsewhere as a decision-making body may in this context teach through the less threatening mechanism of clinical education.

Since the time of Osler,[26] the CPC, or clinical-pathological-conference, has formed an integral part of hospital procedure. At such a conference, the clinician who cared for a deceased patient describes the rationale for his diagnosis and therapeutic course, and the pathologist describes the post-mortem findings.[27] Errors in judgment and astuteness in diagnosis may be discovered in comparing their findings. It has been recently demonstrated that the ethical tribunal may function very well in the context of the CPC.[28] The expert medical participants are already familiar with the confrontation between prediction and result, and the addition of an ethical perspective to this confrontation would not entail much difficulty. Moreover, the CPC deals with faits accomplis, thereby freeing the participants from the strain of deciding upon prospective action.

It is, of course, in the area of experimentation that the most extreme medical dilemmas are likely to arise.[29] The problems raised by the selection of patients and approval of protocols for experimentation are often considered by institutional human experimentation committees.[30] Indeed, the value of such committees acting in both parliamentary and magisterial roles has been recognized for at least twenty years.[31]

One of the more important questions faced by these committees is the determination of when a procedure stops being experimental and becomes either therapeutic or superfluous. The selection of patients is also a difficult process, and there is the danger that in their consideration of the protocols, the committees may neglect to consider adequately the interests of the individuals chosen for experimentation.[32] For these reasons, the ethical tribunal should function in this context as well.

Clearly, there are serious problems in the selection of the members of the proposed tribunals and in the nature of their function and responsibility, the resolution of which must await the trials of experience. One possible selection process would demand a tribunal composed of those who most closely approximate the Philosopher-King. Another would suggest a tribunal whose members are selected at random from the population at large -- an "average" group, as it were.

Yet a third point of view would consider the tribunal incomplete without the incorporation of certain representatives: for example, the inclusion of cancer patients in any discussion of cancer, and the inclusion of children in any discussion relating to them. A theologian might decry the absence of a religious individual, while a Marxist might demand the inclusion of an atheist. A stoic would consider suicide a reasonable course of action at some times, while a Catholic would not. The validity of the decisions reached by the tribunal obviously rests upon one's faith in the fairness of the selection process.

Perhaps the ultimate difficulty, however, is the determination of the nature and extent of the tribunal's responsibility. Having granted the possibility or even the probability of error at some point in the deliberation of ethical issues, responsibility for such error becomes a matter of no small consequence. Consider, for example, a violent patient who is brought before a tribunal as a candidate for an experimental invasive procedure which might alter his behavior patterns.

Consider further the dilemma that might result from a decision against the performance of the proposed procedure, and a recommendation favoring an alternative form of therapy. If, upon the patient's return to the community, he were to harm the life or property of another individual, to what extent should the tribunal be held liable for the damages? Whatever ultimate decision is reached respecting legal liability,[33] it should be clear that moral responsibility for the consequences of one's actions is the sine qua non of ethical behavior.

VI. Conclusion

If certainty could be assured in even some small segment of our activities,[34] we might test the classical notion that man is incapable of ethical error without a concomitant error of intellect or fact. Our attempts to effect social change on the basis of our understanding of ethical principles is subject to the same kinds of error. If pursued further, it could be argued that the adoption of no ethical notion is preferable to the espousal of mistaken moral precepts. But whatever the entangling complications and grievous errors that might result from our attempt to realize an ethical ideal, we admit, by that very attempt, that some ethical notion does exist, and we thereby provide at least some tribute to virtue.

FOOTNOTES

1 For an eloquent description of one physician's encounter with such a problem see Silber, Death's Other Kingdom, Resident & Staff Physician, Jan. 1974, at 89.

2 Guttentag, The Problem of Experimentation on Human Beings: The Physician's Point of View, in Clinical Investigation in Medicine: Legal Moral and Ethical Aspects 63, 64-66 (I. Ladimer & R. Newman eds. 1963). Guttentag's term "physician-experimenter" has been converted into "physician-scientist" to reflect the broader nature of the dilemmas under discussion.

3 See Fox, Some Social and Cultural Factors in American Society Conducive to Medical Research on Human Subjects, 1 Clin. Pharm. & Therapeutics 423 (1960), reprinted in Clinical Investigation in Medicine, supra note 2, at 81.

4 Cf. R. Harris, A Sacred Trust (1966).

5 See, e.g., Guttentag, supra note 2.

6 See, e.g., American Hospital Ass'n., Patient's Bill of Rights (1972).

7 Dyck, Ethics and Medicine, 40 Linacre Q. 182 (1973).

8 Ingelfinger, Bedside Ethics for the Hopeless Case, 289 New Eng. J. Med. 914 (1973).

9 *Id.*

10 Although the legal status of abortion in the United States is changing, see Roe v. Wade, 410 U.S. 113 (1973): Doc v. Bolton, 410 U.S. 179 (1973), prior to the present generation of medical graduates, physicians commonly took an oath, either the Hippocratic or some variant thereof, by which they affirmed their intention to desist from performing abortions. Some physicians continue to decline to perform abortions, lest they violate their oath. See Hospital Tribune, Jan. 14, 1974, at 1, col. 1

11 See J. Rawls, A Theory of Justice 83-90 (1971). Rawls follows established philosophical tradition in differentiating among three forms of procedural justice. "Perfect procedural-justice" is obtained when a performed procedure guarantees a result that an independent standard has established as being just. "Imperfect procedural justice" is characterized by the existence of an independent criterion for the correct outcome and the absence of a procedure that is sure to lead to it. Finally, "pure procedural justice obtains when there is no independent criterion for the right result; instead there is a correct or fair procedure such that

the outcome is likewise correct or fair, whatever it is, provided that the procedure has been properly followed." Id. at 86. The term "procedural justice" is used somewhat differently here. The concept of perfect procedural justice is implied but in a world where the independent criteria for the correct result have not been completely defined. In such a situation, procedural justice itself, however ideal the procedure, is only a part of the totality of justice. The totality must, of course, include the independent notion of right.

12 See R. Brandt, Ethical Theory 241-69 (1959).

13 "The word Sanhedrin in the tractate which bears its name...designates the higher courts of law which in the latter part of the period of the Second Temple administered justice in Palestine according to the Mosaic law in the more serious crimes and especially capital cases." The Babylonian Talmud, 1 Sanhedrin xi (I., Epstein ed. 1935).

14 *Id.*, Ethics of the Fathers 1:6.

15 *Id.* Sanhedrin 90a

16 Plato, The Republic, Book VI.

17 Firth, Ethical Absolutism and the Ideal Observer, 12 Phil. & Phen. Research 317, 1952.

18 *Id.* at 333

19 Although the tribune originally functioned as an individual chosen as a popular representative, he came to work in concert with his fellow tribunes. The powers and functions accruing to the *office* of tribune accompanied the *body* of tribunes protecting the popular interests on the Capitoline Hill. See Pomponius' Manual as cited in Justinian's Digest I:11:2; Plutarch, Roman Questions lxxxl; 7 Cambridge Ancient History 443, 450-56 (S. Cook, F. Adcock, & M. Charlesworth, eds. 1928).

20 Tyranny is the perversion of Kingship; Oligarchy of Aristocracy; and Democracy of Polity. Tyranny is a government by a single person directed to the interest of that person; Oligarchy is directed to the interest of the well-to-do; Democracy is directed to the interest of the poorer classes. None of the three is directed to the advantage of the whole body of citizens.

Aristotle, Politics, III:vii:5
(E. Barker transl. 1946).

21 See, e.g., Mishkin, Multidisciplinary Review for the Protection of Human Subjects in Biomedical Research: Present and Prospective HEW Policy, 54 B.U.L. Rev. 000 (1974).

22 See note 13 supra.

23 See note 14 supra.

24 See Welch, Professional Standard Review Organizations-Problems and Progress, 289 New Eng. J. Med. 291 (1973). For responses to various Professional Standard Review Organizations (PSRO) proposals see Mahoney, PSRO's: What They Are, How They'll Work, Modern Medicine, Oct. 29, 1973, at 25; AMA News, Jan. 14, 1974, at 5, col. 1; id. Dec. 10, 1973, at 4, col. 1.

25 E.G., Brune v. Belinkoff, 354 Mass. 102, 235 N.E. 2d 793 (1968); Douglas vs. Bussabarger, 438 P.2d 829 (Wash. 1968)

26 Sir William Osler (1819-1919), the foremost clinician of his time and the author of a standard textbook on medicine, introduced the CPC as a tool for combining pathological and clinical findings. See generally H. Cushing, The Life of Sir William Osler (1925).

27 CPC's conducted at Massachusetts General Hospital are regularly published in the New England Journal of Medicine.

28 The demonstration was held at a meeting of the AMA Committee on Ethics in Medicine on April 28, 1973, in Washington, D.C., and was conducted by Dr. Melvin Levine of the Children's Hospital Medical Center of Boston, George J. Annas, Director of the Boston University Center for Law and Health Sciences, and Dr. Ned Cassem, a Jesuit priest and a psychiatrist as Massachusetts General Hospital.

29 See Guttentag, supra note 2.

30 See e.g., U.S. Dept. of Health, Education & Welfare, Procedures and Policies of General Clinical Research Centers; Office of the Surgeon General, U.S. Dept. of the Army, Principles, Policies and Rules Relating to the Use of Human Volunteers in Medical Research; Beth Israel Hospital, Boston, Your Rights as a Patient (1973). For a more general discussion of the policing of human experimentation see Mainland. The Clinical Trial--Some Difficulties and Suggestions, 11 J. Chronic Diseases 484 (1960).

31 Cf. United States v. Brandt, Trials of War Criminals Before the Nuremberg Military Tribunals, Vols. I & II, The Medical Case (1948) (U.S. Govt. Printing Office).

32 Cf. Shaw, Dilemmas of "Informed Consent" in Children, 289 New Eng. J. Med. 885 (1973).

33 For a discussion of the question of legal liability see Annas & Glantz, Psychosurgery: The Law's Response, 54 B.U.I. Rev. 000 (1974).

34 See Firth, The Anatomy of Certainty, 76 Phil. Rev. 3 (1967).

The Concept of Taboo
and the Practice of Medicine*

by

Teodoro F. Dagi

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* Draft - please do not quote.

This essay is a still-evolving attempt to formalize a series of impressions. I submit it for scrutiny in the hope of eliciting criticism and correction of errors in usage and approach that reflect my slight training in sociology and anthropology.

The distinction between what is known and what is unknown is often as difficult as it is important. Human behavior seems to respond strongly to an ill-defined demand for some explanation of all experiences - even those which are "unknown." The thought processes accompanying such explanations often contain both rational and non-rational components. The rational components are usually associated with some epistemically satisfying notion of objective truth in the mind of an outside observer. Concepts of empirical observation, of classification, of systematization, and of theoretical simplicity, when present, add credence to the essence of any argument seen or proposed as rational.

The absence of such characteristics, and the presence of complex intuitive notions depending on some special knowledge acquired with difficulty, and reproducible only after special initiation, all indicate the influence of non-rational intellectual persuasion. The rational processes are closely allied to modern notions of science; the non-rational, conversely, are commonly grouped as mystical, magical, praeter-natural, or at times even religious.

The sociologist Malinowski emphasizes similarities between the non-rational and the rational, rather than the differences between them:[1]

> Magic is akin to science in that it always has a definite aim intimately associated with human instincts, needs, and pursuits. The magic art is directed towards the attainment of practical aims. Like the other arts and crafts, it is also governed by a theory, by a system of principles which dictate the manner in which the act has to be performed in order to be effective....
>
> ...Science, even as represented by the primitive knowledge of savage man, is based on the normal universal experience of everyday life, experience won in man's struggle with nature for his subsistence and safety, founded on observation, fixed by reason. Magic is based on specific experience of emotional states in which man observes not nature but himself, in which the truth is revealed not by reason but by the play of emotions upon the human organism. Science is founded on the conviction that experience, effort, and reason are valid; magic on the belief that hope cannot fail, nor desire deceive.... The one constitutes the domain of the profane; the other, hedged round by observances, mysteries, and taboos, makes up half the domain of the sacred.

In his study of the relationship between the A.M.A. and public health legislation, The Sacred Trust, Richard Harris quotes Malinowski, and suggests that just as rational processes can operate in the irrational domain, so can magical beliefs attain significance in the rational domain. This idea is by no means original in Harris. Malinowski himself introduced an essay on "Primitive Man and His Religion" by saying that no part of priritive survival, craftsmanship, or social process could have survived without some belief in the regularity and generalizability of natural phenomena, and that such belief constitutes a "confidence in the power of reason" which entails "the rudiments of science."[2]

Harris, discussing faith in one's doctor as an element in medical practice, quotes the following:

> "Magical beliefs and practices tend to cluster about situations where there is an important uncertainty factor and where there are strong emotional interests in the success of action." Aside from religious practices, probably no human situation fits this description better than that of a person undergoing medical treatment. "The basic function of magic... is to bolster the self-confidence of actors in situations where energy and skill do make a difference but where, because of uncertainty factors, outcomes cannot be guaranteed. This fits the doctor, but in addition on the side of the patient it may be argued that the belief in the possibility of recovery is an important factor in it...."[3]

George Bernard Shaw had no excess of affection for the medical profession. As part of his obligation to educate the British public, he saw fit to warn his readership of the dangers inherently accompanying the practice and promulgation of medical science. In so doing, Shaw touched upon some of the very interdigitations complicating a rational view of human endeavor that Malinowski studied. Shaw, of course, was far from objective in his presentation. Much of Shaw's ascerbity strikes us as droll today, but his literary caveats written in 1913 are not as estranged from contemporary medical critics as one might expect:

> B.B....It is an entirely different bacillus; only the two are, unfortunately, so exactly alike that you cannot see the difference....
>
> Sir Patrick. And how do you tell one from the other?
>
> B.B. Well, obviously, if the bacillus is the genuine Löfller, you have diphtheria; and if it's the pseudobacillus, you're quite well. Nothing simpler. Science is always simple and always profound. It is only the half-truths that are dangerous.... I mean no disrespect to your generation, Sir Patrick: some of you old stagers did marvels through sheer professional intuition and clinical experience; but when I think of the

> average men of your day, ignorantly bleeding and cupping and purging, and scattering germs over their patients from their clothes and instruments, and contrast all that with the scientific certainty and simplicity of my treatment of the little prince the other day, I can't help being proud of my own generation: the men who were trained on germ theory, the veterans of the great struggle over Evolution in the seventies. We may have our faults; but at least we are men of science....[4]

And this selection from The Doctor's Dilemma, quite typical of Shaw and his circle of cynically idealist Fabians both, is preceded by an even more pointed introduction:

> I presume nobody will question the existence of a widely spread popular delusion that every doctor is a man of science. It is escaped only in the very small class which understands by science something more than conjuring with retorts and spirit lamps, magnets and microscopes and discovering magical cures for a disease....[5]

What precisely science does stand for is something which Shaw leaves unspecified. Clearly, however, medicine to him neither occupies a throne in the halls of science nor even belongs on the lists to joust for that honor.

> ...Wise men used to take care to consult doctors qualified before 1860, who were usually contemptuous of or indifferent to the germ theory and bacteriological therapeutics; but now that these veterans have mostly retired or died, we are left in the hands of the generations which, having heard of miracles much as St. Thomas Aquinas heard of angels, suddenly concluded that the whole area of healing could be summed up in the formula: Find the microbe and kill it. And even that they did not know how to do....[6]
>
> The popular theory of disease is the common medical theory: namely that every disease had its microbe duly created in the garden of Eden, and has been steadily propagating itself and producing widening circles of malignant disease ever since....[7]
>
> ...Every savage chief who is not a Mahomet learns that if he wishes to strike the imagination of his tribe - and without doing that he cannot rule them - he must terrify or revolt them from time to time by acts of hideous cruelty or disgusting unnaturalness. We are far from being as superior to such tribes as we imagine....[8]

Just as Catullus, introspecting about Lesbia, described his reaction as "Odi et amo./ Quare id faciam fortasse requiris:/ Nescio, sed fieri sentio et excrucior," so do many read Shaw with what can only be described as an approach-avoidance reaction.[9] And unlike Plato, who was able to write: "...that which is healthy causes health, and that which is unhealthy causes disease,"[10] most people's reaction to medicine conforms more closely to Malinowski's admixture than to any objectively ideal "psychophoresis" of rational and irrational elements. Sigerist comments on this matter when, in introducing and justifying the study of medicine among Shaw's savage ilk, he notes:

> The study of primitive medicine is extremely interesting...it reveals certain psychological mechanisms, certain beliefs and practices that are also found among civilized people today, either as part of what is commonly called folk-medicine or as superstitions that are sometimes widespread even among the educated classes.[11]

Sigerist returned to the Malinowski concept somewhat later in his essay on primitive medicine. He found it necessary to clarify two points: (1) how the evolutionary, almost Chardinian assumption of human progression was warranted; (2) what we mean when we say modern "scientific" medicine is superior to the Primitives. Perhaps the juxtaposition of these two points represents one sort of answer to Shaw:

> Under the influence of the theory of evolution, anthropologists and sociologists in the nineteenth century assumed that the various types of human culture represented evolutionary stages in a development from simple to more complex forms. Indeed it was easily apparent that the Egyptians, the Babylonians, and others had all gone through a scriptless period, had all had a simple technology in the beginning. The similarity of cultural forms was striking, and even in young civilizations - even today among us - magic and religious beliefs are found that are almost identical with those of primitive people; since they cannot be explained by diffusion it is usually assumed they are survivals of early beliefs.[12]
>
> ...Our present chemotherapy of infectious diseases is not only different from the treatment of the same disease by Sydenham or by Hippocrates but is superior, because it cures more people.... Hence, in medicine, we certainly can distinguish between primitive and advanced conditions.[13]

The word "taboo" is often seen in conjunction with discussions of mystical or non-rational practices in clinical medicine. Sigerist, in his study of primitive medicine, mentions taboo in passing, but relates it only to the Polynesian archipelago. The concept of taboo is difficult to define. Even descriptive sources, close as we can get to primary sources, tend to specify taboo more in terms of its limits than its contents. This description of taboo among the Tiwi of North Australia is characteristic of the sources extant:

> The strongest support for the hypothesis that the Tiwi found their environment a friendly and reassuring universe to live in comes from their wide elaboration and reliance upon the negative form of magic called taboo. As a tribe they were magic-free but taboo-ridden. Their generic word for anything sacred or forbidden or untouchable was pukimami, a word which in its most common form referred to a state of special being in which a person or thing temporarily was. Thus mourners were pukimami for the period of their mourning, youths undergoing initiation were pukimami during the ceremonies, a woman who had just given birth was pukimami for a week or two afterwards. Dead bodies were pukimami until buried; graveposts were pukimami once erected on the grave; the names of dead people immediately became pukimami on their deaths and could not be used, and the same was true of all the names bestowed by a dead man on the children of his household and all the other words in the language that sounded similar to the name of the dead man. All ceremonials and rituals were pukimami as were the main performers and the armlets, neck ornaments, and other ceremonial objects. People in a pukimami state had to observe all sorts of avoidances of and abstentions from everyday actions, particularly with regard to food and sex. Close relatives of dead people could not touch food but had to be fed by nonmourners. ...Certain spots in the bush or on the banks of streams were pukimami places; the dimly seen outline of the Australian coast was pukimami as was the ocean near Cape Keith where the Tiwi ancestors had first created the Tiwi world; and finally, the violation of a pukimami restriction rendered the violator pukimami.[14]

The precise relationship between the concept of taboo and the causation of disease is clear neither from the description of the Tiwi nor from the Shavian admonitions of The Doctor's Dilemma. Taboo is but one of a number of non-rational thought processes attempting to explain the unknown and to develop some predictive faculty. Similarly, pukimami is not the only cultural or behavioral manifestation of taboo. The concept of a particular taboo - including or ignoring disease within its province - is as different from the concept of taboo as a Latin declension differs from a generative grammar; but whereas there are many primitive beliefs diluting the rationality of one's relationship to a physician, the beliefs differ from the set of behavioral imperatives which taboo entails. Taboo is important because it represents quality of behavior much as politeness represents a quality of interaction.

While taboo might be very influential, it is not easy to recognize specific instances. The variability of behavior explicable as taboo in primitive tribes - surprising in its scope - is magnified in the course of cultural evolution.

> We must remember that the logic of primitive man is different from ours. The fact that he is inclined to neglect secondary causes, that he does not readily admit that something may happen by accident, and the fact that he firmly believes in magic and in the omnipresence of spirits obviously lead him to different conclusions than we should reach. And yet he is perfectly logical within his own sphere, and we realize it as soon as we accept his premises. The medical field is an excellent example of this because all actions taken are the logical result of the concepts held of disease.[15]

As the concepts of disease undergo cultural evolution and intellectual revolution, the behavioral consequences of these changing concepts vary proportionately. One way of looking at Shaw's physicians is to see them redefining their behavioral imperatives and their intellectual position according to a seemingly newly adopted and certainly contested view of disease. The behavioral imperatives by themselves have two thrusts: (1) the function of the physican within the realm of disease causation (e.g., "the scientific certainty and simplicity of my treatment..."); (2) the relationship of the patient to the physician in view of this function (e.g., "We are left in the hands of the generation which, having heard of miracles much as St. Thomas Aquinas heard of angels, suddenly concluded that the whole area of healing could be summed up in the formula: Find the microbe and kill it.")[6]

The extent to which territorial limitations are imposed on medical practice may be inferred from the introduction to *The Doctor's Dilemma* on the one hand, and the text of the play on the other. In the introduction, Shaw justifies his warrant to criticize the medical profession by the content of the criticism. There is an implication projected that were the medical profession indeed scientific, it would be less subject to external criticism. One senses that were the medical profession, in Shaw's eyes, not expecting to find "magical cures for a disease" through "conjuring,"[5] it would approximate science more closely. Medicine is suspect because it calls itself science when it is not.

Science, however, is still imbued with a notion of sanctity, and herein lies the taboo: Shaw does not say "nothing is holy, including medicine;" he says, rather, medicine thinks itself holy and sees itself tabooed, closed to external judgment *because* it is science. Since medicine is *not* science - and Shaw does accept the notion that some things are sanctified - medicine is not sanctified. Having established this *libet*, Shaw can continue the content of his criticism in the text of the play.

It is worthwhile noting, however, that Shaw the skeptic demonstrates by his justification that he recognizes a limitation possibly operative on his freedom of intellection. The justification then becomes a rite through which the sacred can be approached. The presence of this rite exemplifies Malinowski's non-rational processes, Durkheim's concept of religious life, and Sigerist's observations on vestigial primitive behavior among civilized and educated classes. As will be demonstrated, the rite also indicates the presence of a taboo.

The text of The Doctor's Dilemma portrays and ridicules the relationships between physicians and their colleagues, physicians and their patients, and physicians and scientific concepts of disease. From one point of view, Shaw fulfilled the promise of criticism permitted by the rite of justification by having the physicians in his play bespeak his criticisms. From another point of view, Shaw demonstrated and elaborated another taboo: the taboo represented by a discomfort in criticizing one's colleagues, one's profession, and, in a Chekhovian way, one's real or putative progress. More accurately, these details do not define the taboo, despite the fact that they indicate once again its presence.

The taboo on medicine has, as part of the characteristic of a taboo system or taboo psychology, a series of internal rites congruent to the system of external rites. Just as the Israelites were given a whole set of laws instructing them in their approach to the temple and to the priestly clan, the priestly clan was instructed in its function of approaching the progressive levels of sanctity in the Temple, epitomized in the Holy of Holies. The members of the priestly clan were not themselves special or taboo qua individual members of society. Their taboo emanated from the ritual required for the Temple. At the point where they could no longer serve as priests, they still had certain privileges remaining in virtue of their belonging to the corpus of the Children of Israel, but they could no longer command the same ritual behavior vis-à-vis themselves. They might no longer expect, for example, that the Levites would lave their hands before, as priests, they went to pray.

The priests had additional rites relative to each other, and, of course, to the source of their sanctified social position, the Temple. A great deal of their interaction could be described by the rubric of small-group behavior. Some of it could be explained more readily by viewing the small-group behavior as an attempt to stay within the same clubhouse, and avoid the annoyance of passing from one level of sanctity to another.

To visit the Holy of Holies, a priest was required to dress up in sanctified garb, with the breastplate and mitre of office. He would immerse himself in a ritual bath several times, in rigid sequence. He would purify himself, and sacrifice an animal in respect of his task.

When he would go down among the people, he would require no special ritual to leave, but some rather stringent degrees of preparation to return. The stringency was even more strictly applied when, as part of his function as arbiter, the priest would visit the sick and diagnose who would require sequestration and who might remain or return to the camp. And no one other than the priest had warrant to visit those it was necessary to sequester.

The taboo on medicine operates similarly. There have been authorities who tried to represent the priest-healer kinship as a slow evolution from primitive spiritual leader dealing with disease as part of his authority, to an Hellenic healer who belonged to either an Aesculapiar temple cult, an essentially craftman's class, or a philosophical school with medical implications; to a medieval physician concerned with his patient's soul and charged by his church to save the soul before the body; to the enlightened modern doctor, who practices a rational-empirical medicine but encounters in himself and in others vestiges of religious beliefs dictating the nature of his relationship to the patient and his relationship to disease. This theory is attractive for the systematized notion of simplified continuity which it offers. Since it interprets motives rather than describing behavior alone, and since the evidence supporting the interpretation of these motives is often unclear, this theory is not as satisfying as one would wish.

The concept of taboo, however, is applicable to a type of behavior rather than a psychological attitude. It seems that one can identify the territory it limits even if one cannot identify its Holy of Holies - although one can make a strong argument that the taboo of medicine is epitomized in the taboo of disease and abnormality or deviance from the needs or expectations of society in terms of physical or mental health. Part of the distinction may seem circular, for deviance is often defined in terms of taboo, as is disease.

We are speaking here of behavior, however, and not motivation. The behavior directed towards the sick and the deviant is an example of the class of behavior summarizable as taboo. The behavior directed at medicine and operating within the medical profession may similarly slide down the same wicket. The taboo of medicine, consequently, exists because people behave towards disease and those dealing with disease in a manner which can be called taboo. Why this behavior has evolved is patently unclear. In order to understand it more fully, however, it is useful to consider the concept of taboo from a formal anthropological and sociological approach.

"Taboo," says Steiner, "is concerned (1) with all the social mechasims of obedience which have ritual significance; (2) with specific and restrictive behaviour in dangerous situations. One might say that taboo deals with the sociology of danger itself, for it is also concerned (3) with the protection of individuals who are in danger and (4) with the protection of society from those endangered - and therefore dangerous - persons."[16]

The term was described originally by explorers in the South Seas. Although the taboo which Cook described in his account of the third global circumnavigation became the example which introduced the expression into everyday European usage, his restricted description (which dealt only with the islanders of Atui and with human sacrifice in Tahiti[17]) was soon expanded to include all manner of religious, mystical, and anthropological phenomena. After Cook's death, King, his successor, continued both the journey and its history. King composed this classic passage by which taboo became known:

> Having promised the reader...an explanation of what was meant by the word taboo, I shall, in this place, lay before him the particular instances that fell under our observation of its application and effects. On our inquiring into the reasons of the interdiction of all intercourse between us and the natives, the day preceding the arrival of Tereeboo, we were told that the bay was tabooed. The same restriction took place, at our request, the day we interred the bones of Captain Cook. In these two instances the natives paid the most implicit and scrupulous obedience; but whether on any religious principle, or merely in deference to the civil authority of their chiefs, I cannot determine. When the ground near our observatories, and the place where our masts lay were tabooed, by sticking small wands round them, this operated in a manner not less efficacious. But though this mode of consecration was performed by the priests only, yet still, as the men ventured to come within the space when invited by us, it should seem that they were under no religious apprehensions; and that their obedience was limited to our refusal only. The women could by no means be induced to come near us; but this was probably on account of the Morai adjoining; which they are prohibited, at all times, and in all the islands of those seas, from approaching.
>
> Mention hath already been made, that women are always tabooed, or forbidden to eat certain kinds of meats. We also frequently saw several at their meals, who had the meat put into their mouths by others; and on our asking the reason of this singularity were told that they were tabooed, or forbidden to feed themselves. This prohibition, we understood, was always laid on them after

> they had assisted at any funeral, or touched a dead body, and also on other occasions. It is necessary to observe that, on these occasions, they apply the word taboo indifferently to both persons and things. Thus they say the natives were tabooed, or the bay was tabooed, and so of the rest. This word is also used to express anything sacred, or eminent, or devoted. Thus the king of Owhyhee was Eree-taboo; a human victim tangata-taboo; and in the same manner, among the Friendly Islanders, Tonga, the island where the king resides is named Tonga-taboo.[17]

King described the manner in which taboo was used in one particular culture, together with its limitations and implications in terms of behavior. He defined the word in context, and realized it could be used for both persons and things. It is interesting that King was aware of the subtleties which give taboo different meanings at different times. It is also to his credit that he would think to question the source of the power invested in this concept. By 1791, the word that King introduced had become the property of the educated, particularly in England. The New English Dictionary of that year cites "a plain declaration that the topick of France is tabooed or forbidden ground to Mr. Burke."[18] The New English Dictionary apparently agreed with King, and accepted an almost literally territorial connotation with which to invest the concept.

The conceptual specificity of taboo as a territorial limitation was diluted by scholars who sought to find a universal matrix for religious experience under its aegis. Steiner describes, at some length, the complex linguistic machinations proposed by some of these scholars in an attempt to find an etymological (rather than conceptual) kinship to Sanskrit and Indonesian dialects.[19] No real success met these attempts; overwhelming evidence supported the contention that the word tabu or taboo was of uniquely Polynesian derivation. In studying the phenomenology of taboo, however, the essentially descriptive phenomenological approach of the nineteenth century social scientists extended the province of taboo to include explanations of the putative roots of the Old Testament.[20]

Steiner asserts that taboo, for the Victorian intellectual, was much more than a phenomenon worthy of intense scrutiny. He attributes to taboo an emotional mantle in which the Victorian mind felt completely at home. In introducing the work of Robertson Smith, for example, Steiner makes the point that the Victorians, in studying taboo, were in a manner of speaking studying themselves. This observation he calls the "problem of taboo":

> The problem of taboo became extraordinarily prominent in the Victorian age for two reasons: the rationalist approach to religion and the place of taboo in Victorian society itself. The Victorian era was a rationalist age which differed from the previous Age of Reason in that it attributed importance not only to the various attempts at rational explanation, but also to the residual context which did not yield to the solvent of reason. This was particularly true of religion, which was then being adapted to the needs of an industrial society. Now the ground held by religion could be covered by various ethical theories, but there remained, unaccounted for, some very important human attitudes which were not susceptible to the same type of treatment and which, indeed, seemed irrational under such examination.... Consequently these residual contexts - those which could not be dealt with in terms of ethical rationalisation and subjective theories of value - were put under the headings of magic and taboo, and were favoured with a certain type of objective approach which it became fashionable to call scientific. In this way magic and taboo - that is the odd "do's" and the odder "don'ts" - emerged as the two main categories of religious residua....
>
> There is yet another side to the Victorian interest in this problem and one which cannot be overlooked. Victorian society itself was one of the most taboo-minded and taboo-ridden societies on record. It must not be forgotten that scholars like Frazer grew up among people who preferred, in certain circumstances, to say "unmentionables" rather than "trousers."[21]

In whatever sense the Victorians studied their own religious prejudices while investigating the problem and the concept of taboo, they placed a sociological and anthropological capital on a theistic column. The temple which they constructed enclosed a strict set of attitudes.

When Freud turned his attention to the development of an investigative tool leading to the origins of common psychopathology, he was forced to enter, describe, and possibly profane the temple. Scholars had theretofore accepted the existence of taboo without reservation and with little critical inquiry. They found taboo useful for cataloguing literature across cultural boundaries, and turned the questions they would ask of a Polynesian chieftain to their own religious beliefs in an attempt to specify the rationalistic seats of the Old Testament.

Freud well-nigh ignored the phenomena of religious emotion or abstentive ritual to which an individual might adhere, or upon which an individual might confer a Jamesian title of religious experience.

Freud was much more interested in the substantive range of meaning which, in both everyday and pathological behavior, might be attributed to a notion of taboo.[22] His monograph Totem and Taboo contains the following essays: (1) The Horror of Incest; (2) Taboo and Emotional Ambivalence; (3) Animism, Magic, and the Omnipotence of Thought; (4) The Return of Totemism in Childhood. He summarizes Frazer and Robertson Smith, extracts from Northcote Thomas' elaboration of Frazer's 1875 article on taboo in the Encyclopaedia Brittanica, discusses Wundt's comments in his Völkerpsychologie (1927), and concludes, at one point:

> What we are concerned with, then, is a number of prohibitions to which these primitive races are subjected.... Behind all these prohibitions there seems to be something in the nature of a theory that they are necessary because certain persons and things are charged with a dangerous power which can be transferred through contact with them, almost like an infection.[23]

Two theses are important to Freud: the distinctiveness of sacredness and horror and the difference between them; and the automatic nature of the taboo sanction. From a clinical context, Freud draws comparisons from among social prohibitions, taboos, and states of neurotic and character disorders. The behavioral format which a ritual embodies represents only one of many possible cultural manifestations of social processes. It is the meaning which the ritual incorporates which is the most important issue.

Freud as a social scientist reviewed the anthropologist and sociologist who had, up until his own inquiry, phenomenologically collected and defined the social endeavors which interested him. Freud as a physician cared for patients whom he saw as representing in contemporary psychological apprehension the vestiges of primitive behavior. His interest lay in the human phylogenetical recollection of an ontologically primitive ritualistic pattern, and the symptomatic relief of those states realized when the ontogency became "fixed" at a primitive level. Taboo warranted attention, then, as a representative class of fixation, and as the societal pattern which such a class of fixation internalizes.

Margaret Mead epitomizes the position of those who view the construct of taboo as a specific set of anthropologically generalizable but culturally unique prohibitions, rather than a universally applicable human phenomenon. She schematizes the system of taboo in Polynesia as follows:

> The "Polynesian idea..." contains the following elements: (a) any prohibitions enforced automatically--that is, the punishment followed inevitably without external mediation; (b) or the edicts of chiefs and priests, which are supported either by the superior mana of these individuals or by the temporal or spiritual forces which they have under their control; (c) prohibitions against theft or trespass for which the sanctions are specific magic formulae;

> (d) religious prohibitions which are referred in native theology to the decree of some deity or spirit; (e) any prohibitions which carry no penalties beyond the anxiety and embarrassment arising from a breach of strongly entrenched custom.

She concludes that taboo must be restricted

> to describe prohibition against participation in any situation of such inherent danger that the very act of participation will recoil upon the violator of the taboo.[24]

Mead's conceptual scheme depends on aetiological derivation for intellectual integrity: one cannot understand the meaning of taboo without knowing what cases of law fall under the jurisdiction of taboo in societies which recognize taboo. This approach is equivalent to asserting that one cannot find pointillist or impressionist elements in Second Dynasty Egyptian temple art, since Seurat and Corot only lived at the end of the nineteenth century. There might be a psychologically consistent, if anthropologically naive, perspective from which to view such controversies in the sociology of ritualistic avoidance behavior.

Mead, Freud, or Frazer may well restrict the meaning of taboo, and demand that those who study taboo go no further than an exposition and explanation of the pattern of taboo where it obviously exists. Despite this analysis, however, people often act as though a taboo were active despite (a) the absence of the concept from their specific social system; (b) a readily accessible explanation for a threatening or dangerous situation; (c) the presence of other models of behavior to deal with the threat. In such cases, taboo or its analogue might serve (teleologically, and quite possibly mistakenly) to simplify the classification of codes of behavior in a Goffmanesque way; it would hardly subserve some real or putative fear of Mead's "punishment followed inevitably without external mediation."

It is apparent that at times, the distinction between healthy response simplification and neurotic approach-avoidance behavior becomes blurry. Freud dealt with the obsessional personality at length in Totem and Taboo. The psychoanalytic literature is replete with efforts intending to identify the content of neurotic behavior and demonstrate congruences with anthropologically primitive ritual in other cultures. The argument as commonly encountered consists of an elaboration of Freud's thoughts on intellectual and behavioral phylogeny: many characteristics of neurotic behavior show evidence of regression; these same phenomena occur among "normal members" of "primitive societies." Since we are often at a loss to understand the neurotic's ritual, it might be useful to deal with it as if it were a manifestation of the same types of fears and rituals understood to some extent in other cultures.

In this sort of reasoning, Freud's notion of taboo is obviously extrapolated to accept all of Mead's descriptive categories - so long as one regards the behavior as significant to a higher degree than (a) the explanation for its necessity and (b) the nature of its associated threat. Whether the "taboo behavior" results directly from the edict of some chief, or whether it responds to a prohibition specifically applicable when an individual acts as though there existed a "classical" or narrowly defined taboo (prohibitions enforced automatically, etc.) a strong argument can be made asserting that the behavior is "taboo enough" to be classified under the heading of taboo. It is in this sense of the concept that the remainder of this paper will proceed.

The physician in all but the most modern times fulfilled more than a simple therapeutic role. One might prefer to say that the role *assigned* to the physician in all but the most modern times included extra-therapeutic expectations; the role differs in modern times in that the extra-therapeutic functions are often fulfilled, but less often assigned. In the widest sense of the word religious, the extra-therapeutic functions were often religious: they dealt with the sacred more than the profane, and they implicitly or explicitly recognized (1) the distinction between the sacred and the profane and (2) the unique responsibility which a physician assumed vis-à-vis the sacred.

The uniqueness of this responsibility also had two components: (1) the relationship of everyman to the sacred; (2) the recognized need of the physician to voyage between the sacred and profane relatively unhampered. In speaking of the sacred and of the profane, we are adopting Malinowski's usage, but remaining as faithful as possible to Durkheim's formulation of religion in his *Elementary Forms of Religious Life*. The sacred, then, may be approached - both proximally and conceptually - only after certain conditions often involving or consisting of rituals have been satisfied. The profane may be approached directly, and with no preparation.

As we have seen from the discussion of taboo, notions of sacredness with this breadth of meaning might well apply to disease as well as religious faith. The interactions of insistence on religious ritual, belief in its efficacy, and involvement with disease are not abstruse. The Israelite priest visiting the leprous underwent strict purification patterns before returning to the camp. The primitive healer propitiates the spirits while employing therapeutic manipulations. The Greek physician knew, on occasion, to avoid *hubris*, and refer the patient to the Aesculapian temple.

As Oswei Temkin showed, in more than one text, the "business of the physician" which Sydenham discussed in defending his treatise on venereal disease, and at which others hinted at various times, adopted multifarious rubrics in various jousts with society - albeit with some uniformity of identity:[25]

> There seems to have been widespread agreement from antiquity through the Middles Ages and Renaissance and far into modern times that professional medicine dealt with man's body. With his soul medicine dealt only in so far as behavior was associated with somatic conditions. The physician was the natural philosopher, the physicus, while the philosopher or the priest was the physician of the soul. In antiquity, as Edelstein has shown, philosophers, intent upon the moral guidance of man, used to point to the power of the physician to whom free men entrusted their bodily welfare. In the Middles Ages, the preoccupation with the body gave the physician the reputation of being a materialist or even an atheist. On the other hand, so long as society believed that good and evil were of the soul, not of the body, the physician was not burdened by a concern for the crimes and sins of man....
>
> Orthodox medicine, therefore, meant the proper form for dealing with sickness; it did not always mean love and trust....[26]

Entralgo, on the other hand, in Doctor and Patient, stresses the degree to which the physician was, in fact, entrusted with the keeping of the soul and the practice of virtue. At times, he points out, this warrant defined the "proper form for dealing with sickness." In a delightful paper on "Medicine and the Problem of Moral Responsibility," Temkin shows that there is no conflict between the expectation that the healer of the body would also tend the soul - in fact, primarily tend the soul - and the fact that societies tended to allow the physician independence from overwhelming devotion to the moral ills of his patient; most societies simply did not trust the physician sufficiently to stand on their expectations:

> The physician entered the medieval world as an advocate of the body. There is a curious passage in Psellus' Dialogue on the Operation of Daemons, a work written in the 11th century and fundamental for medieval demonology. One of the persons of this dialogue tells how the monk Marcus explained to him the symptoms caused by the assault of subterranean demons.
>
> "'But Marcus,' said I, 'physicians persuade us to be of another way of thinking, for they assert that such affections are not produced by daemons, but are occasioned by an excess of deficiency of humours, or by a disordered state of the animal spirits, and accordingly they endeavour to cure them by medicine or dietetical regimen, but not by incantations or purifications.' Marcus replied: 'It is not at all surprising if physicians make such an assertion, for they understand nothing but what is perceived by the senses, their whole attention being devoted to the body....'"

> ...I wish to illustrate the new light in which this explanation makes the physician appear. He knows of the body only, and is ignorant of the spiritual order in which disease, as a natural process at least, has no place.[27]

If we take into account the decree of Pope Innocent III of the 4th Lateran Council of 1215, binding the physician to insist his patient confess, and the general supremacy of theology to natural philosophy as an intellectual discipline during the Middle Ages, the following statement would come as no surprise:

> According to the teachings of the Gospel, God did everything in His power not only to protect life, but to preserve and develop it. By facing death in the person of His Divine Son, He crushed death and all threats to life, conquering the powers which endeavor to stifle life or destroy it....
>
> Health protection is a part of respect for life as a result of the vocation God gave us to serve him and all men with all our strength....
>
> At all times the doctor through his art and knowledge must encourage man's desire to live. This is the essence of his vocation. While at most times unaware of it, he is through his profession, a witness of the work of God who, in the person for Jesus Christ, came to destroy the powers of sickness and death in order to save another life....

This statement, however, was written as part of a commentary on clinical investigation in medicine, published in 1963.[28] If this passage be admitted as a modern example of explicit extra-therapeutic assignation to the physician, what of the following.

> ...You do not expect Us to discuss the medical questions which concern you. Those are your domain.... We with to make Ourself the interpreter of the moral conscience of the research worker, the specialist and the practitioner and of the man and Christian who follows the same path....[29]

This passage is extracted from a speech by Pope Pius III to the First International Congress on the Histopathology of the Nervous System.

Clearly, those religious spokesmen who comment on medicine, even in modern times, feel compelled to make some mention of the holiness, of the sacredness, of the vocation that is in medicine. The focus has shifted since the Middle Ages, but not the interest. The physician is no longer seen as a potential purveyor of confession in the face of incurability; he is no longer the advocate of the body by default, being considered too rude a person to deal with the higher matters of truth.

Moral interest in medicine has adopted another integument. Whereas the physician could previously do little, he can now do more. When he could do little, part of the taboo recognized the necessity of freedom of passage as we have already seen. His freedom of passage qua physician, however, was paralleled by another passage - and that was the passage between the City of Man and the City of God. The custodians of the mundane portals to the City of God could only permit the physician freedom on earth if he would assume some responsibility for easy passage to heaven. Afterlife was more certain than the physician's skill. The physicians, it must be remembered, were no less subject to taboo in face of their ritual than the primitives who, by elaborate precautions, use taboo to guard their houses from theft. The moral obligations of the physician, in short, were dictated by his professional responsibilities and capabilities, and these, in turn, were wont to dictate his social position.

Such a relationship is far from unique, of course. Consider, for example, Temkin's analysis of just this point at different historical junctures:

> ...the problem of moral responsibility for disease as presented to the physician is connected with the ethical responsibility of the physician towards his patient... [that] the physician was neither compelled nor expected to act as a moral inquisitor...does not present any particular problem as far as antiquity is concerned. To many ancient philosophers and physicians health constituted a life led in accordance with divine nature and the physician's sole concern with health still remained within the boundaries of the divine. Nor must it be forgotten, that most ancient physicians were traveling craftsmen, sometimes even slaves. Greek and Roman patricians might entrust their bodies to the physician's skillful supervision, but it is not likely that they would allow the socially inferior to meddle with whatever conscience they possessed....
>
> But in the middle ages, the situation was vastly changed. As a Christian, the physician was a member of the spiritual community that embraced all. As a doctor of medicine, he was even a member of the university which resolved religious, metaphysical and legal issues. How, then, could the physician exempt himself from the interest in the soul? In principle, at least, I think that the question was decided on the basis of a hierarcy of knowledge.... Supremacy went to theology. Not being a theologian, the physician need not possess the higher knowledge. But as a consequence he must refrain from interfering where somatic disease ceases and moral guilt begins....
>
> However, the relationship between medicine and moral responsibility is not only dependent on philosophical views. As already indicated it is also determined by the social position of the doctor.... Medicine fulfills a social function. Medicine and society, therefore, must meet on

> a common field so as to speak the same language. In scientific and technical knowledge the physician will be much superior to his patient. But fundamentally both must agree on what should be considered health and disease, otherwise they can hardly get together. But as long as the doctor did not belong to those strata of society that expressed accepted standards, his views were determined by the tradition of his profession and the varying circumstances in which he found himself....[30]

Dr. Temkin continues to show that as the physician moved into the influential strata, he did much to promulgate the moral attitudes of his class. Disease changed from being a demonaic or numinal visitation to becoming evidence of profligacy and moral turpitude. Temkin quotes a passage from Rush's Inquiry into the Effects of Ardent Spirits upon the Human Body and Mind, which, after having designated drunkenness a disease, betakes itself to decry its paroxysms and advise, as part of a medical treatment, a sober and moral existence:

> Yes - thou poor degraded creature, who art daily lifting the poisoned bowl to they lips - cease to avoid the unhallowed ground in which the self-murderer is interred, and wonder no longer that the sun should shine, and the rain fall, and the grass look green upon his grave. Thou art perpetrating gradually, by the use of ardent spirits, what he has effected suddenly by opium - or a halter. Considering how many circumstances from surprize, or derangement, may palliate his guilt, or that (unlike yours) it was not preceded and accompanied by any other crime, it is probable his condemnation will be less than yours at the day of judgements.[31]

A medical manual distributed to assist military surgeons in discharging and enlisting soldiers picked up a similar theme, and directed that men be disqualified who suffer from "habitual and confirmed intemperance and solitary vices in degree sufficient to have materially enfeebled the constitution."[32]

By the beginning of the twentieth century, the extension of medical concern into the moral sphere became somewhat less obviously justified. James Jackson Putnam, professor of neurology at Harvard and Bostonian through and through, was so impressed by Freud's Clark lectures that he began a correspondence, and sought Freud's guidance in bringing psychoanalysis to America. At one point, as he was grappling with the problem of sublimation, Putnam wrote the following to Freud:

> As I study patients and try to relieve them of their symptoms, I find that I must also try to improve their moral characters and temperaments. They must be willing, must wish to "sublimate" themselves; must be ready to make sacrifices and to follow their best ideas....
>
> I consider that no patient is really cured unless he becomes better and broader morally, and conversely, I believe that a moral regeneration helps towards a removal of the symptoms.[33]

One and one-half months later, Freud answered:

> If we are not satisfied with saying "Be moral and philosophical," it is because that is too cheap, and has been said too often without being of help. Our art consists in making it possible for people to be moral and to deal with their wishes philosophically....
>
> ...It is therefore more humane to establish this principle: "Be as moral as you can honestly be and do not strive for an ethical perfection for which you are not destined." Whoever is capable of sublimation will turn to it inevitably as soon as he is free of his neurosis. Those who are not capable of this at least will become more natural and more honest.[34]

In venereal disease, for example, or in drug addiction and alcoholism, psychopathy and sociopathy, and painful or agonizing afflictions, the moral overtones to somatic or psychological affectations still vibrate. Some such conditions represent concomitants of socially reprehensible activities or characterologically inopportune proclivities. In some sense, the moral window through which these conditions are discriminated admits a dark shadow of aspersion on the sufferer: he is labelled by his disease, and is thereby shown to have deserved it. Such a patient is often rehabilitated as well as treated. Only after a "moral regeneration," as Putnam would have it, can one so afflicted be readmitted to full participation in society.

Social reform is mitigating the severity of the gradient which a "morally ill" patient must climb to return to society, but the gradient is still uphill. Despite the hesitation with which such an individual is returned to full personhood, and despite the questioning which those consorting with affected individuals must undergo ere they be adjudged capable of maintaining an immunity to a moral degradation, patients suffering from disease bearing moral judgments are rarely denied medical attention. The physician is permitted to remain morally neutral. Like his medieval colleague, he may adopt, if he wishes, an air of conscientious ethical detachment, and become an advocate of the body.

Such a physician will often be lauded for his kindness. The more he treats those whom others consider in one sense or another untouchable, the more noble he will become; the further into danger he thrusts himself, the braver he will be thought; such behavior on the part of the physician, in contradistinction to the other segments of society, betokens a true medical vocation. Not only is the physician permitted passage between the open and closed camps of social endeavor, he is assigned a *de facto* ambassadorship to represent normality in the sphere of deviance. As he succeeds, as his vocation is fulfilled, the *sacer* applies to him as well: the physician personally becomes part of the sacred, but is privileged to retain the ease of profanity. And if we reexamine our earlier definitions, we may find we have delineated a classical and archtypical example of a taboo.

Margaret Mead, it will be recalled, surveyed the province of taboo, and included within its boundaries:

> (a) any prohibitions enforced automatically -- that is, the punishment followed inevitably without external mediation; (b) or the edicts of chiefs and priests, which are supported either by the superior mana of these individuals or by the temporal or spiritual forces which they have under their control; (c) prohibitions against theft or trespass for which the sanctions are specific magic formulae; (d) religious prohibitions which are referred in native theology to the decree of some deity or spirit; (e) any prohibitions which carry no penalties beyond the anxiety and embarrassment arising from a breach of strongly entrenched custom.[24]

Mead appears to have restricted her discussion to the "Polynesian idea," and her conclusion restricting the meaning of taboo might be most correct when applied to Polynesia. Her conclusion has not inspired universal agreement, as has already been discussed. Let us decline her conclusion, but consider the implications of her analysis.

The prohibitions automatically enforced in medicine deal for the most part with concepts of contagion. The precautionary isolation demanded by the Italian city-states at the time of the plague, the *Quarantina*, is one type of territorial sequestration. It is necessary to recall that the quarantine was required long before any scientific concept of transmission of disease had been developed. The concept of transmission of disease by some profane element could only be accepted by physicians once a religious interpretation for epidemics and infectious disease (as we now know them to be) was discarded.

Sigerist notes that even Jacob Henle who, in 1840, published a pathological treatise stipulating that pathogenic matter must be animated, did not see micro-organisms causing disease.[35] In his classic section on *Miasmata and Contagion*, Henle continued the distinction between miasma, a disease substance which invaded a body from the outside world (e.g., malaria), and contagion, a disease substance believed generated in the sick organism and transmissible by contact (e.g., syphilis). Even Shaw recommended that one seek a physician qualified before the germ theory of disease became widely accepted. Boccaccio, certainly ignorant of Henle's manner of causal distinction, nonetheless could write:

> E fu questa pestilenza di maggior forza per cio che essa dagl 'infermi de quella per lo communicare insieme s'avventava a' sani, non altramenti che faccia il fuoco alle cose secche o unte quando molto vi sono avvicinate. E piu avanti ancora ebbe di male: ché non solamente il parlare e l'usare con gl'infermi dava a' sani infermita o cagione de commune morte, ma ancora il toccare i panni e qualunque altra cosa de quegli infermi stata tocca o adoperata pareva seco quella cotale infermita nel toccator trasportare...
>
> Dalle quali cose e da assai altre a queste simiglianti o maggiori nacquero diverse paure ed imaginazioni in quegli che rimanevano viv; e tutti quasi ad un fine tiravano assai crudele, cio era di schifare e di duggiare gl'infermi e le lor cose; e cosi faccendo, si credeva ciascuno a se medesimo salute acquistare.
>
> \- Decameron, la prima giornata.
>
> And this plague was all the more powerful in that it would come to be communicated from the sick to the healthy, no differently than fire catches when dry objects or fat are brought nigh. And the evil was more blatant still: that not only did conversation or familiarity with the sick cause death, but even touching the clothes or other things used or touched by the sick spread the pestilence unto the toucher....
>
> For these reasons, and for many others similar to these, or even more pressing, diverse fears and imaginings were born to those who remained alive; and almost all tended to one rather cruel goal, that is, to flee and escape from the sick and all their possessions; and in so doing, each and everyone thought to assure his own health.
>
> \- The Decameron, the first day.[36]

Descriptions not significantly different could be read in many newspapers at the time of the cholera epidemic in Naples this past summer.

It seems apparent that with the advent of scientific information concerning the transmission of disease process and the natural history of pathological conditions, the behavior which previously isolated the sick for non-rational reasons became rationally justified. Such teleological justification, however, neither explains nor predicts the emotional component of medically prescribed social sequestration. Jenkins, for example, writing on a technique for determining public attitudes towards illness as a "semantic differential for health," ranked a series of diseases according to social acceptability. Studying a sample of 436 individuals from an urban county in Florida, Jenkins found that some diseases were avoided more than others:

> Why are mental illness and tuberculosis so seldom thought about and discussed? This may be explained by two factors. First, these diseases do not appear to the public to be as prevalent or as threatening when they attack. They are seen as less powerful than cancer and poliomyelitis. Second, these diseases have somewhat more of a cloak of shame about them, as revealed by scale P, whose guide points are "proud, acceptable, embarrassed, disgraced...."
>
> Another approach to the rating of the social acceptability of the different diseases is the scale G, with the end point of "clean-dirty".... Cancer and tuberculosis were perceived quite similarly: both were rated far more dirty than mental illness and poliomyelitis.[37]

How curious that both Boccaccio and Jenkins can use the word "powerful" in describing some characteristic of a disease. Whatever the conclusions might be, the fact that Jenkins can make a case for measuring attitudes towards illness, and, in a presumably statistically valid sample, show that the notion of "disgrace" or of "dirtiness" is not alien to a consideration of disease, indicates that the emotional valuation of disease can still be analyzed in terms of the sacred and the profane. Some diseases are more "powerful;" others are seemingly more "dirty."

The concept of moral and emotional valuation of disease process was projected to the absurd by Samuel Butler in his utopian romance Erewhon. The hero leaves his native England, and, going abroad to seek his fortune, learns about the supposed existence of a mysterious and long lost culture beyond some forbidding mountains. Naturally, the young man succeeds in surviving all dangers, and discovers a civilization in which disease is a crime punishable by imprisonment. Crime, on the other hand, is a disorder to be treated by "straighteners," and carries no moral valuation. It becomes poor form to enquire after someone's health, but quite polite to ask the condition of one's temperament. Ill health results in total ostracism, while legal misadventure is seen as a mere temporary incapacity:

> The fact, therefore, that the Erewhonians attach none of that guilt to crime which they do to physical ailments, does not prevent the more selfish among them from neglecting a friend who has robbed a bank, for instance, till he has fully recovered; but it does prevent them from even thinking of treating criminals with that contemptuous tone which would seem to say, "I, if I were you, should be a better man than you," a tone which is held quite reasonable in regard to

> physical ailment...on the whole they use much the same reserve or unreserve about the state of their moral welfare as we do about our health.[38]

While some of Butler's satire attacks medicine in the same way that Shaw does, a good portion of his Darwinian predelictions attack the Victorian society for its squeamish rejection of the ill. If we wish, we might compare some of these attacks in Erewhon to Steiner's idea of the "problem of taboo" among the Victorians.

That this notion is not totally absurd can be seen from a study such as that by Antonovsky, who describes the interaction between illness and disease; between a disease process, in other words, and the manifestation of the disease vis-à-vis the feeling of the patient that he is sick.[39] While Antonovsky concludes that such determinations made in accordance with social class differences are difficult to establish, he provides an interesting discussion of Kadushin's model of interaction between the "environment and the constitution, history, and culture of the individual."[40] Antonovsky also reviews the studies which prompted Kadushin to study the problem of class distinctions in the first place. Again, we find such distinctions discussed and pondered. Again, we find ourselves in face of that part of a taboo dealing with reflexive punishment associated with the status of illness.

The problem of clinical investigation in medicine - which some physicians have called not just an essential part of medical practice, but even the cord which binds the laboratory to the practitioner - represents yet another example of the polarization of medical activity between the sacred and the profane.[41] The subset of taboo exemplified by behavior involved in clinical experimentation is more complex; we are dealing not only with prohibitions, but also with "the edicts of chiefs and priests, which are supported either by the superior mana of these individuals or by the temporal or spiritual forces which they have under their control."[24]

In discussing clinical experimentation, we must be cognizant of the various relationships inherent. The experimenter must deal with the disease, the experimental therapy, the patient, and the other members of the staff, at the very least. The patient is required to see himself as ill; as an experimental subject; and, as will be seen, a colleague in medicine to the extent that he is advancing medical knowledge. Other medical personnel and paramedical personnel must relate to the patient, the disease, and the experimenter on these levels, but they must also undergo the additional confusion of participating with a patient and treating him. This confusion can be particularly marked when the treating physician responsible for the care and health of the patient is not the one conducting the experiment. Others might maintain, of course, that it is precisely when the two are not identical that the conflict of interest arises and the confusion occurs.

Otto E. Guttentag, in an essay entitled "The Problem of Experimentation on Human Beings: The Physician's Point of View," considers the technical and the historical sides of the physician-patient relationship in clinical experimentation.[42] Guttentag states the problem quite succinctly: one is given mandate as a physician to be privy to a patient in order to benefit him. Clinical investigation bespeaks a biological generalization in which the individuals benefitting are not necessarily identical to those participating in the experiment.

Furthermore, there is no profession outside of medicine permitted to experiment on human beings. Much of this permission is predicated on the unique sense in which society is willing to accept medicine's version of what Firth calls the traditional epistemological problems: "decisions about the relationship between knowledge and certainty."[43] This relationship, in turn, forms the basis for what Guttentag describes as the two types of physician-patient interactions operative in the course of clinical investigation: the normal, healing bond between the physician and the patient, based and sustained in the belief that the physician is interested in the patient for the welfare of the patient and the patient only, and dedicated to relieving the patient of suffering, if not curing the disease entirely; and the experimental contract, which, in accepting the physician as an objective observer, asserts that the identity of the experimenter as a physician is almost incidental, and the contract exists solely because the patient is exhibiting a certain set of symptoms. The first bond, the original patient-physician contract, sees the physician as the "physician-friend"; the second bond allows and requires the physician-experimenter to adopt the type of objective air which functionally renders him "physician-neutral."

Renée Fox quotes the following passage in describing the clinical researcher:

> ...When the clinical researcher goes to his wards his purpose is not to recognize the known, but to face the unknown.... Experimental research upon the sick may verily come into conflict with full solicitude for the sick....[44]

Dr. Fox continues to comment on what happens when the physician-researcher faces the unknown, and what timbre he imparts to the physician patient relationship:

> In addition, clinical investigators often give their subjects what one physician has termed "red carpet treatment." They extend special privileges and considerations to subjects which are not accorded the "usual" hospital patient, such as free room and board in the hospital, free medical services, free supplies of new, scarce drugs, especially attractive hospital accommodations, and so on.

> The manifest functions of the special personal and privileged ways in which clinical investigators treat the persons who act as their subjects and of the ways in which they deal with them as if they were professional collaborators, are obvious.
>
> ...Reinforcing the moral reasons for which physicians give subjects a detailed explanation of the experiments in which they participate is a more pragmatic one. It is their impression that this increases their motivation to act as research subjects and makes them more cooperative about the demands and restrictions the studies impose on them....
>
> In addition, there are certain more latent functions that these informal relations between medical investigators and their research subjects seem to serve. "Thank you for suffering so stoically," a research physician wrote to one of his patient-subjects after he had been discharged from the hospital...."[45]

A swift glance garners a sheaf of elements we have encountered before. The experimenter is dealing with uncertainty; he must often pass between the experimental realm and the therapeutic world; his patient-subject must be treated in special fashion, and, in some sense, propitiated; a moral reproach implicit in the concept of a physician experimenting must be overcome; the patient is treated as a colleague in partial expiation; and the subject is congratulated on having suffered in acceptable style. The ineffaceable prohibitions are obvious. The patient must also respond to the physician's edicts, however, and the physician-friend is at times in conflict because of the physician-experimenter's edicts: part of the struggle becomes attributable to the preference for the edict of the chief with the "superior mana." The structuralist requirements for a taboo have thus been satisfied, and many of the medical rituals operative may be understood as a matter of course.

The evidence we have reviewed has dealt almost entirely with the physician-patient aspect of clinical experimentation. When taboo is present in one sphere of activity, however, those involved in that sphere can be expected to be primed for similar patterns in other areas. The spread of cathexis is particularly powerful, and especially so when the activities of the patient, the physicians, and the auxiliary medical personnel are as closely coordinated as they must of needs be in an experimental situation. There is reason to assume that although the specific relationship which a patient or medical staff might bear toward a specific disease or specific experimental design might differ, the general species of attitude will not stray far from the general pattern of such relationships in the society.

At some point or other in their career, most medical investigators participate in a study on incurable, dying, or otherwise determined "hopeless" patients. There seems to be a widely-held sentiment permitting greater boldness in the face of such tragedy. To some extent at least, this proclivity can as well be understood in terms of taboo. The example of the Tiwi, moderated by the commentary of theoretical and phenomenological anthropologists, can serve to demonstrate the exclusivity of taboo. It is, once again, a conceptual, conversable, personal, and sometimes territorial segregation.

Once within or across the boundary of sequestration, assuming only one taboo is operative, or at least only one form of consequence regardless of number of taboos, there can be no further reaction. To be taboo both entails obligations and relieves obligations, depending on one's social and functional proximity to the sacred, and one's moral imperative determined accordingly. A measure of finality erupts within such boundaries.

The physician, as we have seen, is permitted to transverse the boundary more freely than most other members of society. He is not entirely free: hence his ritual, and his ritualistic moral obligations. The obligations appertaining to passage from the sacred to the profane seem to be in large manner active for the protection of the members-at-large of a society recognizing such boundaries. As soon as an individual becomes established within the sacred category, and endowed with a separate identity, it is no longer he whom the physician must protect, but the rest of society. His moral obligations mediated through the taboo matrix remain immutable to society, but modulated and permuted relative to the patient whose status is now taboo.

From another point of view, the so-labelled patient has become "other" relative to society. The "wholly-other" conforms to part of Rudolf Otto's idea of the holy. This patient has become holy, and therefore requires yet another series of moral obligations unique to his status. Thus the establishment of taboo has denied the patient some measure of protection - that fortifying his defense against taboo. Having become taboo, however, the patient is betaken of the position of the holy, and is treated with great deference, and even with a measure of equality by precisely that segment of medicine charged to discover new means by which to protect society, and decrease, as it were, the province of taboo.

There are a new set of moral obligations which arise when an experimenter resolves to examine the taboo. To begin with, any doubt concerning the status of the patient must be dispelled ere the experiment on the patient begins, if part of the mandate for involving that patient in particular revolves on his taboo status. This admonition is valid regardless of the class of rule under which the taboo is activated: it is true for contagion as much as deadliness, mental illness as much as childbirth. Once the behavior of the physician or experimenter has adopted the trappings of taboo, the patient is taboo, regardless of what doubts were extant previously. This, it must be remembered, is our working definition of taboo, that taboo may be operative even when not defined as such, so long as the behavior is concomitant with taboo ritual.

Part of the new obligation of the doctor, then, is not to act what he doesn't believe. In most cases, the objectivity of the experimenter is challenged once the experiment has begun. In this case, however, the physician-neutral has within his power to determine the social outcome of the disease, of Kadushin's illness, according to his behavior. The paradox lies in this, that the more objective the clinician, the more likely he is to repudiate behavioristically the role of the physician-friend, and the more readily will he discharge the patient to taboo. Without his objectivity, however, he can hardly function as a physician or as an experimenter.

To the extent to which taboo represents danger, there is no more danger once the boundary has been passed. The experimenter can therefore congratulate the patient on having suffered stoically, but not really for having suffered in the absolute sense. The absoluate suffering is inherent within the taboo. The patient who is taboo has moral obligations as well. These are the expectations which society presents even to those on its fringe. In recollection of their full enfranchisement previous to their taboo, members are expected to respect the sacredness thrust upon them. Partially to protect society from the danger of their otherness, and partially to usufruct their utter remoteness, those taboo ought to deny themselves profligacy. Their behavior is expected to be exemplary, despite their hopelessness: they must even suffer well. No doubt the closer one comes to a religious imputation joined to a given taboo, the more readily one might accept or explain the moral rigidity bespoken by some elements of taboo.

The dying patient, proximate but perhaps not yet within the taboo of thanatos, is subject to some of the most primitive mechanisms of taboo as well as some of the most complex systems of modern psychological investment. The issue of whether such a one is subject to a taboo distinct and separate from that of the dead is interesting, but essentially irrelevant. The dying patient is generally accepted as hopeless. He is still alive, however, and the obligations accruing him are still those of the living. He is potentially dangerous, potentially "other" in another way, however, for the dying patient is patently about to become taboo, and wholly forbidden.

The difficulty occurs, then, when the status of the patient twixt the sacred and the profane is in flux. The rituals are unclear; who must be protected from whom is uncertain. Not every dying patient is ill, or subject to taboo of disease. In some patients, the taboo of disease is comfortably ensconced only to be suddenly and unexpectedly supplanted by the taboo of the dead.

The physician is in an especially difficult position, for he cannot choose the correct ritual of passage without determining correctly what he is passing between. His responsibilities are predicated on this clarification, in a manner actually quite reminiscent of the medieval physician's recognition of the higher priority given to theology in determining when exactly he must stop advocating for the body. When the physician wishes to declare death with quick precision, for reason of transplant or other exigency, he meets the junction of two taboo provinces: one is similar to the taboo in clinical experimentation; and the other, of course, is the province of death.

This sort of problem is particularly acute when the physician-neutral to one patient becomes the physician-friend to another. He must pass, then, not only from sacred to profane, but from sacred to sacred; to whatever extent transmission and miscegenation of taboo occurs ex post facto, the physician is warranted in expecting these complications here. Similar arguments may be made for almost any other area of medical endeavor.

Ethical dilemmas tend to be accompanied by conflicts in moral obligation. This statement may perhaps be dismissed as a tautology. There appears to be one way in which the statement becomes significant despite its seeming transparency, however. The significance becomes evident when the moral obligation is interpreted as something which must be done, given an alternative or not, while the ethical dilemma involves something that ought to be done. Understood in this sense, then, a moral obligation can be resolved, when in conflict, only by an action. An ethical quandary, however, can be resolved or not, in fact or in theory: it indicates what ought to be done when something must be done, but gives no sign of temporal pressure.

Moral obligation, as we intend it, establishes some notion of immediacy. It is difficult, then, for a moral obligation in this sense, to be in conflict with another yet be unaccompanied by an ethical dilemma. Certainly this generalization holds true within medicine. The sphere of medicine, however, is full of obligations and rituals. Many of them, as we have shown, can be identified as taboos. It would seem, therefore, that taboo might serve an interesting role in studying the question of ethical imperative in medicine as well.

The exigencies of taboo are in some measure exigencies of protection. The physician can expect to encounter ethical dilemmas where his relationship to different taboos is unclear. His primary moral obligation is often to act. His action is often predicated on ritual dictated by his proximity to the holy and the necessary of his passage between the holy and the profane. When an ethical dilemma is encountered, it too often bears the force of the holy. Whatever one does, in short, is wrong.

The more taboo-ridden the area of medicine in which the physician is working, the more likely is he to uncover an ethical dilemma sooner or later. It is probable that a stable taboo will have been internalized with sufficient force to be threatened only when many other taboos interacting with it are in flux. If the stable taboo itself is in flux, the removal of its stability from the field in whose manor the physician works is much more likely to threaten the rituals determined elsewhere. This notion is akin to the wedge concept in ethical development: the extension of liberty is often easier than the initial liberation of an obligation.

However a taboo might choose the planes along which to dissect, the taboo represents behavior which is ritualized to simplify proper approximation and eloignement from the holy, and proper intercourse with the profane. The generalization of moral imperative and ethical obligation within an individual's construct is paralleled by the construct of the collective mind of the community, and thence are derived both taboos and accompanying non-ritualized obligations. This manner of derivation, of social integration, is intended phenomenologically rather than ontogenically.

Even this distinction, however, can be further analysed into the components of medical practice which are affected by taboo behavior, and which, independent of their taboo, if that be possible, contain intrinsic moral worth and ethical imperative. In that taboo subserves a non-rational behavioral matrix and includes components of valuation, sacredness, invitation, terror, and territoriality, taboo represents an essential element in the comprehension of human behavior. The normative part of ethical theory hopefully includes a goodly weight of rational process: anent taboo, therefore, its relationship to ethical theory is circumjacent to the metaethical and the strategic. A full discussion of this relationship is beyond the scope of this essay.

To function rationally in the practice of medicine requires comprehension of the non-rational motives in action. Where the non-rationality includes the physician and the disease, as well as the social function of the patient, I believe the notion of taboo can serve a cross-cultural, cross-morbid, and cross-temporal simplifying and unifying purpose.

FOOTNOTES

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JAMES R. MISSETT

Dr. James R. Missett was born in Philadelphia, Pa., on December 6, 1941. His early and secondary education was in parochial schools in West Hartford, Connecticut. As a Basselin Foundation Scholar at the Catholic University of America, he was awarded a B.A. and an M.A. in philosophy. His master's thesis was on "Church and State in the Political Philosophy of James Madison."

After two years as a teaching fellow at the St. John's University Philosophy of Science Institute, he entered Yale University School of Medicine. There he served on the Editorial Board of the Journal of the History of Medicine and Allied Sciences; was president of the School's Student Council; and was a member of the Committees on Medical Ethics and Interprofessional Education. He was awarded the Upjohn Achievement Award upon graduation with honors from Yale in 1970. He is a member of the Alpha Omega Alpha National Medical Honor Society.

After an internship in internal medicine at the Stanford University Medical Center, Dr. Missett entered the United States Public Health Service as Special Assistant to the Administrator of the Health Services and Mental Health Administration. In that capacity he served as co-chairman of the HSMHA Task Force on Human Value Issues in Health Care, and was selected as a member of the DHEW-AAMC Medical Mission to Poland in September, 1972.

In June, 1973, Dr. Missett was awarded his doctorate in philosophy from St. John's University. His dissertation concerned Man as Other-Directed: Speech and Sexuality. During that same June he received a dual appointment as a Global Community Health Fellow in the USPHS and as a Fellow of the Institute on Human Values in Medicine. In that capacity he undertook a study in the Department of International Health at the Johns Hopkins School of Hygiene and Public Health of selected ethical issues in international health.

Dr. Missett is currently a resident in psychiatry at the Stanford University Medical Center.

He is married to the former Maureen A. Kenney, a nurse-midwife. They have one child.

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STUDIES OF SELECTED ETHICAL ISSUES IN INTERNATIONAL HEALTH

Submitted by

James R. Missett, M.D., Ph.D.

During my six months as a Fellow in Human Values and Medicine, I studied in the Department of International Health at the Johns Hopkins University School of Hygiene and Public Health. Dr. Carl Taylor, Chairman of the Department, served as advisor for my project.

As originally envisioned, my work was to consist of three parts:

1. An examination of the implications of the World Health Organization's definition of health as it relates to the concept of health care as a right in four countries representing historically different cultural traditions: Poland, India, Tunisia, and Peru.

2. A delineation of the possible limits for a transcultural ethics of medical care through a study of the relationship between ethics, manners, and custom in the provision of health services in these same countries.

3. An examination of whether (and if so, in what way) the same ethical standards as are required in the United States should be applied to health research and delivery projects supported overseas with American dollars.

Because the general area of concentration was on ethical problems in international health, the above objectives have since been expanded to include the following:

4. A study of the ethical implications of the foreign-trained physician (FMG) in the United States, with particular attention to fixing the type and degree of responsibility for action in respect to different problems here and abroad created by his presence in this country.

5. The ethical implications of political decisions determining membership in WHO with particular attention to North Korea, East Germany, Israel, and Rhodesia.

The work schedule called for reading and writing in these areas through late May. Work is proceeding simultaneously on all of these projects, and is in varying states of completion. Work on the FMG situation is the furthest along. I have appended an abstract of a paper I have developed on this subject: "Ethical Aspects of the Foreign Medical Graduate Question in the United States."

Information on the concept of health care as a right in four different countries and on the ethical implications of WHO membership decisions is being collected through a series of interviews, in the former instance with physicians from these afore-mentioned countries who are at present students at Johns Hopkins University, and in the latter instance with senior government and Pan American Health Organization officials in Washington, D.C.

The study of ethical standards in international biomedical research is based on a study of documents in the Department of State, NIH, and the Office of International Health, DHEW. That paper is scheduled for completion in mid-April.

The greatest amount of personal satisfaction during this year has derived from the uncharted possibilities of most of this research. It is an untouched field, and the opportunities for productive scholarship are enormous. Possible areas of study include the following: the extent to which ethical considerations depend on a critical mix of economic and political resources, the ethical characteristics of the "healer" in various societies, and the relationship of growth in ethical consciousness to the development of political sophistication.

It is my hope that the series of papers resulting from this year's work can be published as a book on ethical issues in international health. If it appears at the end of May that there is too much work in proceeding with the idea of the book, then each of the five studies will be published separately as articles.

D/

Abstract of

"Ethical Aspects of the Foreign Medical Graduate Question in the United States"

by
James R. Missett, M.D., Ph.D.

Although there is a long history of physician migration to the United States, the present and continuing entry of large numbers of doctors into this country can be traced back to the passage of the Smith-Mundt Act in 1948. The immediate practical result of this Act was the increased entry of foreign-trained doctors on an exchange basis. Many of these doctors had been actively recruited by hospitals who had lost the services of their American physicians to the army in Korea. The flow of doctors into the U.S. was further enhanced by PL89-236's changes in the immigration laws in the mid-1960's. This influx has been aided by the designation of this country as suffering from a physician shortage.

The numbers involved in this migration are impressive. Between 1961 and 1971 over 76,000 foreign-trained physicians entered the United States. There were 31,000 FMG's in this country in 1963, but over 63,000 in 1973. FMG's thus comprise over 1/6 of the physicians in the United States. In 1971 there were more FMG's than American-trained applicants for state licensure.

Ethical issues arise both from the numbers of individuals involved, the health status of their native countries, the problem of rich nations enticing health manpower out of poorer countries, the potential injustice imposed on physicians if they are singled out for immigration restrictions, and the role of physician emigration in reducing internal pressure on government health authorities to restructure their systems of medical education and health care delivery.

The loss of trained health manpower by poorer countries imposes a heavy burden on them; and the proportion of FMG's entering the U.S. from underdeveloped countries rose from 45% in 1956 to 58% in 1966. Most ECMFG certificates are now going to doctors from developing countries. In addition, many more FMG's have been staying in this country than have been returning home.

The reasons for this situation are many. There is the general comparability of medical education, the presumptive international compatibility of the M.D. degree, the lack of attractive practice opportunities in many foreign countries, the reluctance or inability of

many of these countries to alter the structure of their health care delivery system to make medical practice more attractive, the excellence and stimulation of many of the training and practice opportunities in the U.S., the felt need of many hospitals for additional medical staff, and the relatively small physician output from American medical schools.

It is felt by the author that ample evidence exists to call the present situation objectively unjust. At the very least, every individual has some right to adequate health care as a subsidiary to his rights to fair treatment and to life. The obligations to respect and to honor these rights is imposed differently, however, upon different groups. For instance, the most direct obligation in distributive justice for seeing that medical manpower is physically available to assistance in the maintenance and preservation of life rests with the individual's community and government. The obligation of the individual medical graduate in a foreign country to remain and treat his fellow citizens may rest in justice if one argues that he has an obligation to pay back those whose taxes have supported his education. At the very least, however, there must be some obligation in beneficience on the part of the FMG. Only the most over-riding considerations would, therefore, justify the FMG's ignoring the needs of his fellow countrymen and denying them his services by his leaving the country.

Even if it can be argued, however, that these obligations do not directly touch the responsibilities of individuals and social bodies in the U.S., a case can be made for apportioning responsibility for remedying some of the more glaring aspects of this situation. For instance, one might legitimately maintain that the United States Government has some obligations in justice, founded on its common membership in the community of nations, to restrain itself from engaging in practices or encouraging situations which result in direct, measureable harm to the individuals of other nations. Present immigration policies which encourage the entry of FMG's into this country might be one example of such a practice.

The various professional organizations might legitimately be bound to re-examine their own policies in regard to the encouragement of doctors' leaving their own countries for practice in the United States. The influence of such organizations as the AMA, the AAMC, and the AHA would seem in itself to be a compelling reason for these groups to look at the effect their actions in regard to the FMG situation have on other populations in the world. Those policies which might be looked at most closely include the ones touching on the relatively restrictive admission policies of most American medical schools, the encouragement of more hospital training slots than can possibly be filled with American graduates, the touchy issue of quality monitoring in training programs and actual medical practice, the question of proven facility in the English language before licensing.

The crux of this study has to do with the appropriate apportioning of responsibility between the various groups concerned with the FMG situation. For instance, distinctions are drawn between the type of responsibility required in this matter of the foreign government involved, of the foreign medical schools, of the FMG himself, of the United States government, of the various professional organizations in the United States, and of the individual recruiting hospital. In general, the argument is made that, the further removed one is from the actual harm resulting from his practices and from responsibility for caring for the lives and livelihood of the individuals involved, the more his responsibilities are based on beneficence rather than upon justice.

"Ethical Reflection on Problems of International Health"

by
James R. Missett, M.D., Ph.D.

Although an abstract of this paper is not available at this time, its table of contents (see below) suggests the nature of Dr. Missett's essay. It is available from Dr. Missett or from the Office of the Institute on Human Values in Medicine.

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WILLIAM J. WINSLADE

William J. Winslade has a Ph.D. (1967) in philosophy from Northwestern University and a J.D. (1972) from the University of California, Los Angeles. He is currently a clinical research associate at the Southern California Psychoanalytic Institute.

Mr. Winslade has taught philosophy at the University of Maryland and University of California, Riverside. He has also been actively involved in two experimental education programs in law and philosophy: The Law in a Free Society Project (Los Angeles) and the Center For High School Philosophy (Amherst, Mass.) On July 1, 1974, he will join the law firm of Tuttle and Taylor in Los Angeles.

Mr. Winslade has published articles in metaphysics, legal and political philosophy, and philosophical psychology. His current research interests concern interconnections among law, philosophy, and psychoanalysis, and in particular issues related to insanity and responsibility.

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PHILOSOPHY, LAW, AND PSYCHOANALYSIS
vis-à-vis
LEGAL AND MORAL RESPONSIBILITY AND INSANITY

Submitted by

William J. Winslade, Ph.D., J.D.

During the tenure of my fellowship I began the first stages of a systematic study of various connections between insanity and responsibility. The primary task that I set for myself during the summer was to survey a wide variety of literature in philosophy, law, and psychoanalysis, and to study carefully selected works. I also gave considerable thought to how I would apply what I learned during the summer to my teaching and other professional activity. Through conversations with others with interests similar to mine, I learned a good deal of background information, particularly in the area of psychoanalysis where I do not at present have technical training. I will comment here upon my reading and conversations with others, and discuss teaching and other professional activity below.

I began my reading by studying carefully a recent book by Herbert Fingarette, a psychoanalytically-oriented philosopher, called The Meaning of Criminal Insanity. Although the book provided a useful review of basic issues, cases, and theories, it did not lead me to the theoretical understanding of criminal insanity promised by the author. However, certain ideas concerning the importance of the capacity of persons who commit crimes and other harmful acts are applicable to my own research into negligence and recklessness. I spent some time thinking about the concept of diminished capacity as an excuse in criminal law and the law of torts.

But it is necessary to probe deeper to understand the emotional and physiological roots of impaired mental capacity. This led me to explore the thorny topic of unconscious motives and intentions. Although I got some help from the study of the psychodynamics of accidents, I found the literature voluminous but repetitive in much the same way as the literature on criminal insanity. In neither the law nor psychoanalysis has there been a following-out of the implications of the research to help explain and control typical cases of negligence and recklessness which are all too common in our culture.

As a result of my preliminary reading, I have tentatively concluded that it will be necessary for me to develop my own theoretical framework for organizing and analyzing the data in other areas of research which have a bearing on my own work. Although I feel comfortable in dealing with legal and philosophical literature and problems, I am less at ease in assessing psychoanalytic data. During the summer I began to participate in the Los Angeles Psychoanalytic Society Discussion Group at the invitation of Professor Peter Loewenberg, a psycho-historian at UCLA. At these meetings and through subsequent conversations with various individuals, I began to acquire some useful background information. However, to acquire the necessary skills in psychoanalysis, I have applied to the Southern California Psychoanalytic Institute to participate in their clinical research program for non-medical scholars. Through this program I hope to gain the deeper understanding which I need to successfully carry out my long-range research goals.

After reading Fingarette's book, I had the opportunity on several occasions to discuss the central thesis and related issues with Herbert Morris, professor of law and philosophy at UCLA. As has often been the case in the past, the discussions with Morris proved extremely fruitful, not only in coming to terms with fundamental issues but also in stimulating my own thinking. I also sought to get a better understanding of the issues underlying Fingarette's views by reading some of his other works, including On Responsibility, The Self in Transformation, and Self-Deception. At some time when my research is further along, I hope to meet and talk with Fingarette, who teaches at the University of California, Santa Barbara.

I mentioned previously that I did general reading in accident research. But I read a variety of things, ranging from relevant articles in Psychology Today to technical articles and books in psychoanalytic theory. One book that contains insights particularly useful for my purposes is Thrills and Regressions by the late psychoanalyst, Michael Balint. This book, recommended to me by Dr. Eugene Pumpian-Mindlin, has provided me with some valuable clues about personality types (such as thrill-seekers) that are prone to act recklessly. I have begun to follow up these suggestions and study further various types of persons who engage in high-risk activity, and to attempt to determine what, if any, connections there are to reckless conduct.

Another book that was and continues to be quite helpful is Thought and Action, a much neglected book by a philosopher, Stuart Hampshire. He brings together contemporary philosophical ideas about action, intention, and responsibility with psychoanalytic conceptions of consciousness and human freedom. Although the book is written with little regard for organization into paragraphs, and as a result requires the reader to construct his own map of the various paths and detours of the argument, the book is exciting and suggestive. I have found that the book is extremely useful as a teaching device and, even more importantly, it has stimulated my own research into unconscious intentions and their connection with consciousness and control. This is all the more surprising, because I had read Hampshire's book shortly after it was published in 1960; I now realize that I failed to grasp the importance of the way in which he explores a cluster of central issues germane to responsibility.

One area in which I did not accomplish as much as I had hoped was in the analysis of the broader issues of public policy outlined in the first paragraph of my research proposal. I stated that I intended to examine the roles of the medical and legal professions in articulating standards of responsibility and determining the place of insanity as an excuse. Although I have given thought to some of the broad issues of public policy, I need to formulate a more detailed plan of attack. I hope, during the current academic year, to seek the advice of both lawyers and doctors in getting a better grasp of the important issues. In the course of the seminar on insanity and responsibility that I have helped to organize for the Spring Quarter at UC-Riverside, some of these issues will be formulated and discussed. However, I am disappointed that I have not made more progress in this area. I now realize that it would be extremely useful for me to spend time at a medical center or a government facility to obtain a first-hand view of the practical problems that give rise to the need for theoretical understanding. Equipped with this sort of practical experience, I would be in a much better position to develop useful theories. Although I had hoped to do some of this at UCLA during the summer, I found that other work occupied too much of my time.

I have already indicated some of the ways in which my understanding of my subject has developed as I have sought to mark out a broad set of interconnected issues for research. I am beginning to discover relationships that I had not previously realized, but it would be premature for me to claim that I have a clear picture of the theoretical and the practical landscape. The direction of my research interest has not changed substantially, if at all. I have begun to realize, however, just how complicated are the issues that I have chosen to study. At the moment I am in a period of conscious and perhaps unconscious reflection about how best to organize the data I have collected. Because I am using much of the material in the two courses that I am teaching this fall (see below), I have an opportunity to think through some of the issues in a new way. I expect that I will be in a much better position by the end of the spring quarter when the interdisciplinary seminar on insanity and responsibility is completed to attempt a synthesis of my theoretical ideas.

You have asked whether I see aditional possibilities for the humanities and the health professions to enrich each other. One area in which I feel that much work needs to be done is professional responsibility of personnel engaged in the delivery of health services. During the summer of 1972 I served as a consultant to a joint effort of UCLA Extension and various departments in the university--social sciences, law, philosophy, public health, etc.--to establish a co-operative program in the human services. At that time I proposed a variety of reasons why formal study in both the theory and practice of professional responsibility would be useful. But with so many programs of this type, it was smothered by the bureaucracy, at least for the time being.

I am convinced that the humanities can play an important role in the general education of persons who will enter the public health professions. But at present there are few systematic efforts in established programs in the humanities to develop a comprehensive program, at least as far as I know. I can think of a variety of interesting and valuable lines of study that undergraduates as well as persons in professional training might undertake. For example, a careful study of the works of Thomas Szasz along with M. Foucault's Madness and Civilization would be extremely useful in gaining an historical understanding of the concept of mental illness. This work, along with some analytical material which critically examines the strengths and weaknesses of Szasz's views, would be valuable to anyone. Because all of us, in one way or another, are participants in situations involving health care, an historical and philosophical understanding of mental health is extremely desirable.

One of the courses I am teaching this fall is "Philosophy of Mind." The course is devoted to analysis of human action, intention, recklessness, negligence, and motives. I use not only philosophical but also legal and psychoanalytic literature which raises a variety of issues concerning insanity and responsibility. For example, I am exploring the possibility that many legal problems concerning negligence and recklessness can be explained in terms of unconscious tendencies toward self-destruction. Some of the research on accidents provides illuminating data and theoretical insights. The general question we have examined is whether persons who act from unconscious or semi-conscious motives should be held responsible for their conduct. It has been helpful to compare and contrast such persons with those who are typically thought of as insane.

This in turn has led us to consider the criteria for classifying persons as sane or insane for both moral and legal purposes. Thus we have discussed criteria such as consciousness, volition, control, and related notions. We have moved back and forth between theoretical ideas in philosophy and law to actual cases drawn from legal and medical histories. Without the benefit of my summer research, I would have been unable to see and to explain the interconnections between philosophy, law, and psychology.

Another course I am currently teaching is "Philosophy in Literature." The course is organized around a study of guilt, shame, and responsibility. The reading includes a collection of articles from law, philosophy, psychoanalysis, anthropology, and literary criticism in Guilt and Shame, edited by Herbert Morris. In addition, the students are reading the following novels: The End of the Road by John Barth, Stavrogin's Confession from Dostoyevsky's The Possessed, Crime and Punishment by Dostoyevsky, The Trial by Franz Kafka, and The Death of Ivan Illich by Tolstoy. The theoretical articles are used to gain insight into the complex case studies presented in the literature. Throughout the novels the topics of insanity and responsibility recur in a variety of different ways. In the case of both Stavrogin and Raskolnikov, for example, the question of their sanity is an explicit theme which is repeatedly raised by Dostoyevsky. The reader is forced to reflect upon the grounds for and the consequences of declaring a person to be insane. As a result, one is also moved to think about the importance and limitations of responsibility for human action. Because my summer research has given me a greater understanding of the background of these issues, I am able to explore the problems in greater depth. I might add, however, that in some ways my task becomes more difficult as I begin to discover how complicated the problems are.

During the winter quarter I will teach a course entitled "Philosophy, the Constitution, and the Supreme Court." Among the topics that I will discuss are several which are connected with responsibility and insanity. For example, I will examine Powell v. Texas, a case which raises the question whether a chronic alcoholic should be considered to be suffering from a disease which excuses him from responsibility for public behavior. I will also consider whether persons who are declared mentally defective or insane should be prohibited from procreation and perhaps be subject to compulsory sterilization as was proposed in Skinner v. Oklahoma. I will also discuss the bearing of insanity on issues such as the death penalty and the responsibility of juveniles. I have not yet fully worked out my ideas in this area.

I am happy to report that a new course which grew directly out of my research during my fellowship period will be offered in the spring of 1974 at UC-Riverside. I have attached a memo which describes the preliminary plans for a seminar-lecture series on insanity and responsibility. Since the memo of October 1, the plans for the seminar have crystallized further. There will be a weekend seminar followed by a series of seminars on various aspects of insanity and responsibility. We are presently waiting for responses to invitations which have been sent out to a number of possible participants, including Abraham Goldstein, Dean of the Yale Law School and author of The Insanity Defense, D. L. Rosenhan, Professor of Psychology and Law at Stanford and author of a recent article in Science entitled "On Being Sane in Insane Places," and several others. All of the persons with whom we have discussed the seminar are quite enthusiastic about the idea and have expressed an interest in participating. Several persons, including Professor Alan R. White, Ferrens Professor of Philosophy at The University, Hull, England, who has written numerous articles on philosophy of mind and philosophical psychology, and Herbert Morris, Professor of Philosophy and Law at UCLA, have already agreed to take part in the seminar. I will provide a full report of the details at a later date.

My summer research will be of value in a brief seminar which I will teach in the Spring at the Center for the Healing Arts in Los Angeles. The seminar will be open to persons in the professions--law, social welfare, police, and public health. The seminar will focus on the topics of guilt, shame, and responsibility as they arise in the everyday experience of the various professionals. I am looking forward to some fruitful interaction resulting from the theoretical ideas I present to persons with a practical interest in insanity and responsibility. I will provide the Institute with additional information about this class as well as the others mentioned previously after they are completed.

You asked whether my fellowship work has caused me to plan any specific changes in the scope, organization, and presentation of my discipline, or in the scope or approach of my research and writing. At this point in my career it is difficult for me to forecast the precise direction that my subsequent work will take, but I am confident that I will continue to pursue the interdisciplinary problems undertaken during this research. It has become increasingly clear to me that many of my philosophical interests cannot be sharply separated from practical problems in medicine and law. My teaching, research, and writing interests have begun to turn to cultural issues that require a broad humanistic outlook. I sometimes feel uneasy about the possibility of comprehending such difficult issues, but they cannot be ignored. As I stated in my research proposal, I intend to write for both a technical and a popular audience about some of the problems of responsibility.

I am presently at work on a book on intention, recklessness, and negligence. I am examining these phenomena from the standpoint of law, philosophy, and psychoanalysis. A first draft of the book has been completed, and I am in the process of revising the organization of the book, partly in the light of the work I did this summer on the emotional roots of intentional, reckless, and negligent behavior.

You also asked whether I have discovered areas for further investigation. One such area concerns empirical research into the phenomena of negligence and recklessness. I have in mind the possibility of devising some method of testing attitudes and feelings about negligence and recklessness. Although this idea did not occur to me until recently and it is still quite ill-formed, it seems to me that with the help of qualified social scientists, a technique for gathering information (for instance, from children, parents, and teachers) about negligent and reckless conduct could be developed. The subjects to be interviewed (or perhaps observed) might be presented with hypothetical or simulated situations which would call for their conscious responses to risk-taking. Although a limited amount of work has been done in this area, much more is needed. One thing which is lacking is a study of the connection between attitudes and tendencies toward risk-taking, and beliefs about responsibility to oneself and others.

One further item that I thought might be of interest to the Institute is a meeting I attended about a Group Dynamics Course for Freshman Medical Students at UCLA. I discovered that many persons in the medical school were quite interested in the humanistic dimension of medical school education, but were at a loss about how to begin to incorporate humanistic values into the medical school curriculum. There was a great deal of confusion about just what medical students need in the way of specific training about human relationships while in medical school. It reinforced my belief that undergraduate education must bear much of the responsibility for providing potential doctors and other professionals with the humanistic perspective necessary for understanding and coping with the many problems of interpersonal relationships.

Riverside: Department of Political Science

October 1, 1973

TO: Dean Michael D. Reagan
College of Social and Behavioral Sciences

RE: Proposed symposium/lecture series on Insanity and Responsibility

You asked that Bill Winslade and I provide you with an outline of how the law and society symposium on insanity and responsibility would be organized in order that you would have a clearer basis on which to request foundation support. Our discussions have led to several changes in our original thoughts on how we might fruitfully conduct the symposium; we might more appropriately refer to our present plans as a lecture series or seminar series than as a symposium.

We now propose that we (S&B, S&B and Humanities, or S&B and a foundation, or some other combination) sponsor and organize for the spring quarter, 1974, a series of seminars entitled "Perspectives on Responsibility and Insanity." The series would be oriented mainly, but not exclusively, toward undergraduates. Competent scholars from the fields of law, psychiatry, philosophy, and the social sciences would present their positions, analysis, and/or research to participants in the seminar over a period of five to six weeks. A major goal of the seminars would be to cause their members to grapple with the range of important issues surrounding the notions of responsibility and insanity and their use in our society. We feel that a seminar series will offer a better opportunity for achieving this goal than a brief symposium.

The seminar series should begin, we believe, with an optional weekend seminar in the mountains for a group of no more than twenty-five students. Between Friday evening and noon on Sunday, members would examine and discuss responsibility and insanity, and gain a basic familiarity with the topics on which the invited scholars will focus in the succeeding weeks. The film on Geel...may be used. The seminar would be led by Bill Winslade and one or two other persons.

The participants in the weekend seminar would serve as a core for the series of sessions to follow. Enrolled students would receive one unit of academic credit; in order to maximize the likelihood of continuing involvement in the seminar series, we propose that it be formally listed as a course for which students may receive two units of credit (students who complete both the weekend and the ensuing series would earn three units in total). They would have to meet certain reading and paper requirements, of course, in order to obtain academic credit for the program.

For the five weeks following the weekend session, invited scholars from the disciplines listed earlier would lead seminars on various topics related to responsibility and criminal insanity. For example, an academic lawyer might discuss problems in the use of the insanity concept in criminal proceedings; a psychiatrist might analyze the relationship of psychiatric notions of mental defect/illness with the concept of responsibility; and an anthropologist, variations in the procedures used to deal with insanity and responsibility across cultures. Students would acquire a familiarity with the ways in which the concepts are used and their implications as viewed by representatives of different intellectual concerns, and a capacity for interrelating them in developing their own positions.

The particular format for interaction between the visiting scholars and undergraduates, graduate students, faculty, or members of the local community remains to be decided. We probably would want to take advantage of the visitors for at least one full day and an evening.

The series of seminars would be concluded by another rather intensive session--shorter than a weekend--in which participants attempt to integrate the material to which the series has exposed them. Students who took the sequence for credit would be required to complete a paper.

The range of issues related to the concepts of insanity and responsibility are sufficiently broad that they should be able to arouse the interest of many members of the UCR and Riverside community. Besides the obvious candidates, we would hope to enlist the participation of some people in the UCR-UCLA medical-clinical program. It would also be useful and instructive to have the theater department present a play illustrating some of the major issues with which the series will deal. As well, given the frequency with which insanity and responsibility have played roles in literature, some members of the English department may be able to contribute and receive something of worth in the seminars.

These are our ideas for the basic structure of the program which we propose. Among the many problems, large and small, which will have to be met are the following:

- What to require of the invited scholars. If we orient the program mainly toward undergraduates, is it satisfactory to require a lecture in written form suitable for publication? How long should we keep them? In what kinds of formats? How large an honorarium?

- How should we offer academic credit for the series? Through an E-Z number, a new course number, in either of two colleges (for example, as a Humanities XXX or a Social Science YYY), or otherwise?

- If a UCR faculty member wanted to be one of the scholars in the series (e.g., Art Bohart, who has already indicated an interest in delivering a paper), could he be paid anything extra for presenting a paper?

- Financing: figuring an average of $400 apiece, we could invite five major participants (although transportation and local room charges complicate matters) with a budget of $2000. That still leaves money for local arrangements such as advertising, room charges, receptions, etc., with which a grant from a foundation could certainly help. Is sufficient money available?

- How should the "results" of the seminar series be published? Law review, a format like the Journal of Social Issues, or otherwise?

These are our thoughts on the symposium-turned-seminar-series; we will continue to develop them and to involve other UCR people in the planning process, and we look forward to receiving your reactions.

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Enclosures

Outline of A Critical Discussion of

Paul Ramsey's The Patient as a Person

by William J. Winslade, Ph.D., J.D.

Introduction: Description of the book and Ramsey's view of medical ethics followed by a statement of my thesis.

A. The Covenant Model.

    1. Nature of covenants.

    2. Visibility of the model in the book.

B. Primacy of Persons.

    1. Person-oriented vs. benefit-to-mankind medical morality.

    2. Tensions between these moralities.

C. Doctrine of Consent.

    1. Nature and significance.

    2. Joint venture/partnership ideal (positive aspect of consent).

    3. Prevent overreaching (negative aspect).

    4. Application of consent principle.

        a. Role of moralist and physician.

            (a) Meaning of and criteria for applying consent principle.

            (b) Satisfaction in particular cases.

        b. Implied consent.

        c. Research on incompetents.

        d. Ambiguous situations.

        e. Kidney and heart transplants. Centrality of consent?

D. Objections to Ramsey's position.

    1. The covenant model--too general and vague?

    2. Consent and respect for persons.

    a. Consent is not a necessary condition for respect for persons.
    b. Consent is not a sufficient condition for respect for persons.
    c. The joint venture/partnership ideal has limited application.
3. Obstacles to establishing a person-oriented medical morality.
    a. Attitudes of doctors.
    b. Attitudes of patients.
4. Conclusion.

A Critical Discussion of The Patient as a Person

Paul Ramsey's latest book, based on his 1969 Lyman Beecher lectures at Yale University, is subtitled "Explorations in Medical Ethics."[1] Although Ramsey is not exploring an uncharted area, his book is exploratory because he straddles boundaries which usually separate theology, philosophy, law and medicine. His analysis ranges over a variety of moral dilemmas of contemporary medical practice. For example, he discusses the significance of consent in therapy and experimentation, the moral importance of the criteria used for determining when a person has died, problems which commonly arise in caring for the dying, difficulties surrounding the transplantation of vital organs, and issues pertaining to the fair distribution of sparse medical resources.

Ramsey is troubled by the fact that many discussions of the problems of medical ethics "remain at the level of surface intuitions or in an impasse of conversation-stoppers" (xv). How is it possible to go further? Codes of ethics provide only minimal guidance. The turbulent state of medical ethics today can be calmed only if the fundamental moral principles underlying the codes are "constantly pondered and enlivened in their application" lest "they become dead letters" (xvi). In contrast to classical Roman Catholic textbooks on medical ethics, Ramsey believes that there are no fixed rules from which solutions to moral dilemmas of medical practice can be deduced.

> Medical ethics today must, indeed, be casuistry; it must deal as competently and exhaustively as possible with the concrete features of actual moral decisions of life and death and medical care. But we can no longer be so confident that the "resolution" or "solution" will be forthcoming (xvii).

It should not be inferred, however, that Ramsey endorses a "situational" approach to ethics. Instead, fundamental principles of Christian morality are articulated and applied to particular cases in the context of medical therapy and research. The Patient as a Person is a study in applied normative ethics.

My discussion focuses upon a cluster of ideas which serve as the foundation of Ramsey's moral position. The doctrine of covenants and the principle of consent are analyzed in connection with Ramsey's emphasis upon the moral primacy of persons in medical contexts. I argue that the broad scope and exaggerated significance which is given to the principle of consent leads Ramsey to blur important distinctions between consent and respect for persons. In addition, I examine some deeply rooted practical obstacles to establishing a person-oriented medical morality.

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[1] The Patient as a Person (New Haven and London: Yale University Press, 1970). Hereafter this book will be cited in the text by page number only.

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As a Christian theologian, Ramsey pictures the human condition in terms of what I shall call the covenant model. Covenants are not merely deliberate and voluntary agreements among persons; Ramsey believes that covenants arise from nature, choice, or need (xii). It is difficult to be sure what covenants are, for they seem to encompass natural, moral, metaphysical, and spiritual relationships among persons. Ramsey believes

> that covenant-fidelity is the inner meaning and purpose of our creation as human beings, while the whole of creation is the external basis and condition of the possibility of covenant. This means that the conscious acceptance of covenant responsibilities is the inner meaning of even the "natural" or systemic relations into which we are born and of the institutional relations or roles we enter by choice, while this fabric provides the external framework for human fulfillment in explicit covenants among men. The practice of medicine is one such covenant. Justice, fairness, righteousness, faithfulness, canons of loyalty, the sanctity of life, hesed, agape, or charity are some of the names given to the moral quality of attitude and of action owed to all men by any man who steps into a covenant with another man.... (xii-xiii)

Ramsey places great emphasis on the "sacredness" or "sanctity" of life in all respects and at all stages: fetal, mortal, bodily, living, and dying. In non-theological terms, Ramsey puts his basic question in the following: "What are the moral claims upon us in crucial medical situations and human relation, in which some decision must be made about how to show respect for, protect, preserve, and honor the life of fellow man?" (xiii)

Despite Ramsey's own commitment to the covenant model, which he articulates in the preface, this conceptual framework "is not a very prominent feature" in the remainder of the book (xii). One reason for this is that a great deal of attention is given to the translation of technical, medical, and moral issues and cases into plain language. Another reason is that Ramsey writes with an eye to his agreement and disagreement with writers of various persuasions because he believes that "[t]here is in actuality a community of moral discourse concerning the claims of persons" (xii). But it is important to keep the covenant model in mind, if only to have an appreciation of the perspective from which Ramsey views the problems of medical ethics. I will try to show later that the influence of the covenant model leads Ramsey astray in his discussion of the doctrine of consent. Before turning to consent, however, I wish to explain more fully Ramsey's stress on the "claims of persons."

The moral principle of the primacy of persons sets limits to the proper use of medical technology for either therapeutic or experimental purposes. In terms of fundamental moral principles, this implies that in medical practice a deontological, person-oriented morality should prevail over a teleological, benefit-to-mankind morality. Ramsey contends that the primary responsibility of the physician and the researcher is to respect the autonomy, integrity, and choices of the persons who are patients or experimental subjects. In therapeutic situations this means that the person rather than the disease should be the target of medical care. A physician who cares about and for his patient provides comfort and relief always, and cures if he can. It does not mean, for example, that a physician should prolong life at all costs only to win a pyrrhic victory over death. In experimental situations, respect for persons implies that subjects of medical experiments must always be mature, informed, and consenting individuals who are treated as "joint adventurers," not clinical objects (6).

Ramsey does not deny that there is a tension between a benefit-oriented and a person-oriented morality in medical situations. The tension arises as these fundamental moral attitudes pull us in different directions. Because of the moral primacy of the relationship between a doctor/investigator and a patient/subject as persons, doctors must lean against the natural temptation to neglect or to subordinate respect for patients as persons for the sake of the greatest medical benefits for mankind as a whole.

The covenant model and a person-oriented medical morality are elaborated further in Ramsey's doctrine of consent as a "canon of loyalty" (2). "Consent" means a "reasonably free and adequately informed consent" (2). Complete information or total freedom would only parody the consent requirement. Ramsey points out that "[a] choice may be free and responsible despite the fact that it began in emotional bias one way rather than another, and consent can be informed without being encyclopedic" (3). The significance of the consent requirement for Ramsey is that it "is a statement of the fidelity between the man who performs medical procedures and the man on whom they are performed.... Consent expresses or establishes this relationship, and the requirement of consent sustains it" (5).

Consent is important because it recognizes the patient as an active rather than passive participant in medical situations. "An informed consent," Ramsey writes, "alone exhibits and establishes medical practice and investigation as a voluntary association of free men in a common cause" (11). He goes even further when he asserts that consent makes the patient/subject a "joint adventurer" (6) with the physician/investigator. Ramsey thinks that therapy as well as experimentation should be characterized as a joint venture "in which patient and physician can say and ideally should both say, 'I cure'" (6). Hence he thinks that partnership rather than contract provides a better model for understanding the consensual relationship.

Although the preceding analysis brings out what Ramsey calls the "positive" aspect of the consent requirement, there is a "negative" dimension as well. If capacity to consent makes a joint venture possible, the doctor/investigator's "propensity to overreach his joint adventurer, even in a good cause, makes consent necessary" (6). The negative aspect of the consent requirement places limits upon the benefits for mankind that can be wrung out of therapy or experimentation at the expense of the person/subject. Thus consent is not a single act, but a "continuing and repeatable requirement" (6). Ramsey goes too far when he says that "[t]he patient or subject must be constantly engaged in" consenting (6). Consenting is not an activity, like walking, talking, or thinking. Ramsey is correct, however, in thinking that consent, once given, is always subject to revocation. The presumption is that in a stable situation it remains in effect unless it is terminated.

With the positive and negative aspects of the consent requirement in mind, let me now turn to the application of the consent principle. First I will examine the respective roles of the moralist and the physician in the ethics of the consent situation, especially in determining the criteria for meeting the requirement of "reasonably free and adequately informed consent." Next I will consider both the limitations and the implications of the consent principle in the so-called Good Samaritan cases and in the treatment of or experimentation upon children, incompetent adults, and prisoners. Finally I will discuss the bearing of the consent principle on kidney and heart transplants.

With regard to the respective roles of the moralist and physician in applying the consent principle to actual cases, Ramsey has this to say:

> A theologian or moralist, of course, is not the one to say anything about "ethics in the consent situation." He cannot tell us what the principle of an informed consent requires in actual application. This, physicians and investigators and boards of their peers must do. That is to say, the practical applications of the requirement of an informed consent is always the work of prudence, which does not mean caution but practical wisdom in the appraisal of cases and specific situations (3).

At first glance it seems that the moralist has nothing to say about the application of the consent requirement, for physicians are charged both with determining the criteria in particular situations for a reasonably free and adequately informed consent, and with seeing that the criteria are satisfied. But Ramsey goes on to qualify his position as follows:

> [T]he practical question is always about the meaning of the consent requirement in concrete cases of its application. About this a moralist knows nothing unless he happens also to be a physician-investigator, or has at least acquired considerable specific knowledge of all that is at stake in the case or sort of cases in question (4).

There are two separate issues that Ramsey does not make fully explicit. One issue concerns the meaning of the consent requirement and the criteria for applying the principle in particular cases. The second issue concerns whether or not the criteria have been met in particular cases. With regard to the first issue, physicians seem better qualified to determine what constitutes adequate information than to determine whether consent is reasonably free. It would seem to me that a medically well-informed moralist (or perhaps a morally sophisticated physician) should be consulted on the question of freedom. As I will argue later, those contexts in which consent is most important are those contexts in which it is least likely that the criteria for reasonably free consent can be met.

With regard to the second issue, once the criteria for consent have been established, it does not seem to be a matter requiring the special knowledge of physicians. Of course, one must understand the criteria. But the questions "Was he adequately informed?" and "Was his consent reasonably free?" are factual or evidentiary questions for which medical information is relevant. Perhaps the reason why Ramsey played down the role of the moralist is because as a practical matter the actual decisions in ordinary cases will be made by physicians. But it is important, nonetheless, to realize that not only medical decisions are being made, but also moral and evidentiary judgements. Since physicians are the decision-makers, they have a special responsibility to become morally sophisticated. It does seem to me that a medically well-informed moralist, though he is not usually called upon to render decisions, does have the responsibility to evaluate and criticize the moral-medical decisions made by others.

Regardless of who specifies the criteria for applying the consent principle, the principle should be applied, Ramsey thinks, to most medical situations. However, "one clearly definable exception from the requirement of expressed consent...is the sort or class of cases in which consent may properly be assumed or implied when men are in extreme danger and cannot themselves consent explicitly" (7). Why does Ramsey extend the consent requirements to include "assumed or implied" consent? The traditional doctrine of implied consent, which has spawned numerous difficulties in the law, is a stumbling block for Ramsey as well. Instead of stretching the consent principle too far only to cut it back by carving out exceptions, it might be preferable to restrict the scope of the consent principle in the first place. The class of cases Ramsey is concerned about, such as unconscious or comatose patients, need not be treated as exceptions to a more restricted consent requirement. It might be argued that in such situations the question of consent does not even arise because the person in question lacks the capacity (temporarily or permanently) to give consent. Therapeutic treatment is justified here, as in the case of incompetent children or adults who also lack the capacity to give consent, on the grounds that those who are in need should be given medical care. Although there may be more than one moral basis for providing satisfaction of vital medical needs, such as benevolence or a doctrine of human rights, the role of consent is negligible.

Another modification of the consent principle is made when Ramsey discusses research involving incompetent children or adults; he argues that such persons should not be made experimental subjects except as a last resort for therapeutic reasons. "One has to proportion the peril to the diagnostic or therapeutic needs of the child" (12). Unless an investigation is believed to be of some benefit to the particular patient, it ought not to be undertaken. "To experiment on children in ways that are not related to them as patients is already a sanitized form of barbarism...." (12) Moreover, Ramsey insists that "[n]o parent is morally competent to consent that his child shall be submitted to hazardous or other experiments having no diagnostic or therapeutic significance for the child himself" (13).

Because imcompetents lack the capacity to consent, no one has the moral authority to consent for them to any non-therapeutic experimentation. Ramsey carries this principle out to its fullest extent, for he would prohibit even the drawing of blood for non-therapeutic purposes. The corollary to the consent principle that Ramsey appeals to is this: "No persons may be used as a subject without his will" (25). Although it may seem at first glance that Ramsey goes too far in prohibiting minimum or negligible risk experimentation on incompetents, the motivation for his strong position undoubtedly results from his awareness of the shocking abuses of children in institutions. He discusses in detail some of the ways in which children, sometimes with and sometimes without their parents' consent, have served as human guinea pigs. In light of the practices which Ramsey documents (40 ff.), I would be inclined to agree with him.

Ramsey mentions in passing that there are other situations which present difficulties and ambiguities if one tries to apply the consent principle, such as when the patient's knowing enough to give an informed consent may alter the findings sought when the experimental subjects are prisoners (or sometimes medical students), or when the participants are paid. Ramsey does not say how he can deal with the problem of adequate information in the first class of cases. The stringency of the consent requirement as interpreted by Ramsey would seem to disallow any such experimentation. On the other hand, it could be argued that the criteria for adequate information in such cases might be limited to informing the subject that he cannot be adequately informed. However, there might be cases in which even that information could not be revealed without impairing the experiment.

In the case of prisoners or medical students, experimentation would be morally foreclosed by Ramsey's principle. When Ramsey is explicitly discussing the consent principle, he does not face this problem; he later indicates that prisoners are not morally acceptable donors for major organ transplants; they are in an inherently coercive situation, so the reality of their consent is always subject to grave doubts. Although prisoners have the capacity to give consent, they are not in a position to exercise that capacity freely. Apparently Ramsey thinks that paid participants, though less constrained than prisoners, may be "under too much duress for them to consent freely even if fully informed" (8). Yet Ramsey goes on to say that "[d]espite these ambiguities, however, to obtain an understanding consent is a minimum obligation of a common enterprise" (8). In view of the significance Ramsey attached to the consent requirement, it would seem more appropriate for him explicitly to exclude ambiguous cases; instead he seems to suggest that these are cases in which the consent requirement can be satisfied. It is curious that he leaves these issues unresolved.

The last class of cases involving the consent principle that I want to mention concerns transplantation of major organs, such as kidneys and hearts. In the case of kidney transplants, the question of consent is crucial both when one is considering donating or considering receiving a kidney. In the case of heart transplants, the most important problem concerns consent to becoming a recipient of a heart transplant. Although there are many different issues which arise in connection with these major organ transplants, I wish to consider only one general issue.

It is hard for me to see how satisfactory criteria can be established for determining whether consent is "reasonably free" in such extreme situations. The psychological and emotional pressures generated by relatives or friends, the medical condition of a patient who may be under heavy sedation or in considerable pain, and the fear of death are only some of the factors which constrain freedom to choose. It is interesting to note that Ramsey mentions the consent principle and assumes that it applies to such contexts; he also realizes that the inherent tensions and conflicts restrict the freedom of the relevant consenting party. As a result the criteria for "reasonably free and adequately informed consent" must be extremely weak if one wishes both to allow kidney and heart transplants, and also to insist upon the centrality of the consent requirement.

My own view is that the consent requirement is really not central in such contexts. Consent is only one among many relevant factors which should be considered. However, I would argue that lack of consent, even if it is not reasonably free and adequately informed, should be sufficient to preclude transplantation. A rational and justified decision must be based on a weighing of values and a careful assessment of medical and moral costs and benefits. Ramsey seems to recognize this himself (pp. 196-7), but he makes no attempt to reconcile his emphasis on the centrality of consent with the difficulty of establishing conditions in which consent can be "reasonably free and adequately informed." Perhaps the most that we can hope for is that many precautions are taken to prevent or to counteract duress and coercion which may lead to a parody of the consent requirement.

In the course of my discussion thus far, I have mentioned a few minor doubts which I have about Ramsey's views. I now want to raise some additional objections. The first concerns the intelligibility of the covenant model. I am not at all sure that I understand, much less appreciate, the appeal of the covenant model. The notion of covenant as explained by Ramsey seems so inclusive that every significant moral relationship between persons is based upon a covenant. At the same time such a picture of the human condition seems so general and vague that the covenant model fails to explain anything in particular. Thus we are forced to look closely at the specific doctrines which elaborate the covenant model--the consent requirement and a person-oriented medical morality.

A person-oriented morality, as I understand it, has at least one main root in Kantian ethics; the essential notion is that free and rational (i.e., autonomous) moral agents should never be treated as means only, but always also as ends. Another way in which this principle is sometimes expressed is that the obligation to have and to show respect for persons is a (if not the) fundamental moral principle. Ramsey endorses this doctrine, and seeks to link it very closely with the "positive" and "negative" aspects of the consent requirement. The question which I wish to examine is this: What is the precise connection between the principle of respect for persons and consent? I submit that the consent requirement is neither a necessary nor a sufficient condition for upholding the principle of respect for persons. Because Ramsey exaggerates the significance of the consent requirement, he fails to stress important distinctions between these doctrines.

Consent is not a necessary condition for expressing, establishing, or sustaining (Ramsey's words) the principle of respect for persons. A physician has a duty to treat his patients as persons even if they do not or cannot consent to treatment. The very fact that a physician may refrain from treating a patient who will not consent exemplifies respect for the person's autonomy. Suppose a person cannot consent to treatment because he lacks the capacity, temporarily or permanently, to consent. A physician who treats such a person need not invoke the fiction of implied consent. Instead the physician can appeal to his duty to care for a person who is in need of help. This duty stems from the principle of respect for persons; caring for those in need is one way in which respect is made manifest. A person who is ill or injured is in danger of losing his capacity to think and act as a free and responsible person. The task of the physician is to help restore the person, at least to make him whole physically. (The extreme case is the treatment of an unconscious person who unsuccessfully attempted suicide. The moral basis of the paternalistic act of treatment is to seek to preserve the person as a moral agent.)

Nor is the presence of consent sufficient for either establishing or for sustaining respect for persons. Even if a patient has consented to treatment, a physician may treat the patient in a disrespectful manner. This may occur in contexts in which consent is not even a prominent feature of the situation. For example, suppose a person suffering from a severe sore throat consents to have an examination and perhaps laboratory tests. The question of consent typically does not explicitly arise; the very presence of the patient in the doctor's office is taken to be a sign of consent. Yet in such a case the doctor may or may not treat his patient as a person. It all depends upon the manner in which the doctor behaves toward the person, whether the doctor shows kindness, compassion, patience, concern, etc. Consent is only one element of a complex set of attitudinal and behavioral factors which are relevant to a person-oriented medical morality.

Another way in which Ramsey seeks to expand the significance of the consent requirement is to view the relationship between the physician/experimenter and the patient/subject not as a contract, but as a partnership, a joint venture, or a joint adventure. But this picture is illuminating in only certain situations. The idea of a joint venture seems most appropriate in cases of pure experimentation or extraordinary therapy involving experimentation. But even in that context the extent to which the patient-partner can participate is limited by his lack of knowledge, skill, and often by his physical condition. I might mention in passing that a joint adventure, rather than a partnership or a joint venture, more aptly characterizes pure experimentation or experimental therapy.

The idea of a partnership makes sense in characterizing the relationship between an obstetrician and an expectant mother. Perhaps the omniscient and omnipotent role of the doctor (and of nurses) should be minimized to give the "patient" the primary active role. In many therapeutic situations, however, the idea of a joint adventure is clearly inappropriate. Even the notion of a partnership or a joint venture seems a bit strained. Suppose I am suffering from a painful eye infection. Am I a partner with my ophthalmologist? Cooperation may facilitiate recovery, and to that extent my participation might be viewed as part of a joint venture. But at best there is a limited partnership to which I contribute my body and my willingness to cooperate. The doctor is surely the senior partner. In many cases the notion of a partnership seems obviously out of place. Is having an appendix removed really a joint venture? What about having an ingrown toenail removed?

Although I have tried to show that Ramsey puts too great a theoretical burden upon the principle of consent, I agree with him that a person-oriented medical morality is appropriate in many medical contexts. There are, however, some obstacles to its acceptance in both theory and practice. Ramsey does not discuss these issues at all, but it is important to bring them out.

One of the obstacles to the acceptance of a person-oriented medical morality among doctors is that traditionally doctors have been trained to assume a clinical, detached attitude toward their patients. It is said that such an attitude makes it easier to perform the routine technical and mechanical tasks of daily practice. It is argued, also, that emotional involvement with patients is undesirable for at least two reasons. It is sometimes said that emotional involvement may interfere with performance of delicate acts of surgery or even routine medical tasks which require inflicting some degree of pain. It is also argued, with some plausibility, that emotional involvement with patients can produce too great a strain on a doctor's own psychological and emotional well-being.

One of the dangers of detachment, however, is that it may often seem to be, and can easily degenerate into, an attitude of indifference to the person who is ill. The ironic result may be that a physician may at least appear not to care about the person he is supposed to care for. One superficial symptom of the treatment of patients as clinical objects rather than persons is the tendency to refer to patients by their disease and room number rather than by their name. This convenient form of identification may also reflect an attitude--perhaps only subconscious--that doctors are treating diseases rather than persons.

A failure to distinguish between emotional involvement and respect for persons may also help to account for the tendency to treat patients as clinical objects. There are not just two alternatives--detachment or involvement. Respect for persons is characteristically accompanied by a set of attitudes, beliefs, and modes of behavior which includes, at least, care, concern, compassion, appreciation of the other's values, tolerance, giving of options, absence of coercion, honesty, discretion, etc. It is not uncommon (but not for that reason excusable) that respect as manifested in these various ways of thinking and acting is confused with emotional involvement. But respect for persons is compatible with both detachment and involvement; the appropriate behavior varies with the context.

Of course, no one would deny that too much emotional involvement can impair judgement as well as action, and too much detachment, as I already have suggested, can degenerate into indifference. We would expect there to be differences between the way in which respect is exemplified by a brain surgeon, a heart surgeon who performs transplants, a doctor who treats patients for minor ailments in a student health service, an obstetrician, a doctor in a war zone, or a pediatrician. It is easy enough to imagine the variety of different types of conduct within each of these categories as one takes into consideration the variations among patients, their particular diseases, familiarity or unfamiliarity with their condition, etc. Without attempting to elaborate further, it should at least be clear that there is no simple formula for characterizing a person-oriented medical morality in all contexts.

Patients, not physicians alone, stand in the way of a successful person-oriented medical morality. Some persons think of doctors as mechanics who are supposed to tinker with bodily machines in need of repair. Doctors are expected to be clinical, detached, and efficient. Such patients no more want to be treated like a person any more than they wish to treat doctors as persons. They merely wish a doctor to render services to them (at any time on demand), for a doctor is merely an instrument for serving them when they are ill. Others, however, deify doctors, thus standing both in fear and in awe of them. Such persons often want and expect physicians to treat them paternalistically. Typically they have very high, often unreasonable expectations about the ability of a doctor to provide them with a cure. But often high expectations are thinly disguised false hopes. In such a case the essentially ambivalent attitude toward the doctor may bring about a drastic shift in attitude. From an attitude of trust, confidence, and hope mixed with fear and a feeling of helplessness, a disenchanted patient may become distrustful, uncertain, angry, and cynical. It is important to note that the two types of patient that I have described lack an appreciation of the doctor's competence and of his humanity. Patients with such attitudes toward doctors are not open to genuine trust relationships and mutual respect any more than doctors who see patients only as clinical objects.

Although I am in sympathy with Ramsey's efforts to reach across disciplinary boundaries to speak to a diverse audience, I have attempted to show that his explorations are hampered by distortions in his conceptual framework. I have also tried to point out why Ramsey's worthy ideal of a person-oriented medical morality is (unfortunately) so remote from many areas of medical practice.

CROSS-DISCIPLINARY STUDIES
IN COMPLEMENTARY FIELDS

LESLIE J. ATKINSON

Leslie J. Atkinson is a campus minister and ordained clergyman who has had a long interest and involvement in the social and ethical ramifications of biomedical research and health care delivery. This interest began with his undergraduate education at UCLA when he began in pre-med, and continued through his military training where he served as a hospital laboratory technician in a U.S. Army Hospital. This period of military service included much advanced schooling of a highly technical nature in biochemistry, immunology, and hematology. Upon his return to UCLA, he began to prepare for his theological education and the ministry.

The two interests began to merge when, upon graduation from seminary in 1962, he began to meet with some faculty members from the College of Agriculture at the University of Arizona in a small religious discussion group. As he began to discuss the nature of their work with them and their colleagues, he discovered that many were involved with research projects with profound social ramifications such as genetic manipulation, toxic residues of pesticides in vegetables, ingestion of toxic materials, brain damage caused by dietary deficiencies, etc. Many of these same people were very busy in the various academic committees developing the then future College of Medicine at the University of Arizona. In the summer of 1966, he was asked to become a participant as the theologian-ethicist in a bi-weekly faculty discussion group composed of zoologists, microbiologists, chemists, a physicist, a philosopher, and a political scientist. By this time he was commonly understood to be the Chaplain to the biological community at the University.

In the fall of 1966, he was asked to accept an interim campus ministry assignment at UCLA where it was hoped that he could develop the same kind of work as he had at the University of Arizona. The timing (and funding) for such work was not right, and in 1967 he was asked to begin the first full-time Protestant campus ministry at the University of California, San Diego, a campus already noted for its scientific orientation. In addition to establishing a broad-based campus ministry and responding to the campus turmoil of the late 60's, he has been extensively involved with interdisciplinary education, both as a teacher and a student. He has taken one or two courses a year in University Extension dealing with the question of human values and the resolution of value conflicts. One of these classes, "Today's Morality: Ethics in Wonderland" was chosen for observation by the Carnegie Commission for Innovation in Higher Education. As a result of undergraduates' enrolling in these Extension courses, he and his colleagues were asked to conduct interdisciplinary classes and to serve as tutors for independent study projects for undergraduates.

He has also collaborated with medical school faculty in seminars, research, and programs of interpretation and education to the general public. As a result of this kind of interest and involvement, in 1971 he was asked to join a Student American Medical Association national project on "Change in Medical Education" where he was one of two non-medically trained persons in a group of sixteen. In 1969, he began graduate work on a part-time basis at the University of Southern California in Social Ethics, focusing on medical ethics. This was a broad interdisciplinary program in which the major portion of the course work was in the School of Religion in addition to work in the Schools of Medicine, Public Administration, and Law. He has received his M.A. and is currently completing the Ph.D. degree in Social Ethics and Medicine.

Mr. Atkinson has been deeply involved as a churchman with a number of community groups, and has thus gained wide exposure to the roles that different social and cultural patterns and expectations play as these groups interface with the major social institutions of our day. He has been called upon to serve as a participant or consultant to many church-related agencies and programs concerned with social problems, social ethics, or medical ethics health care delivery.

He is especially concerned with questions of religion and social change; how social and cultural values shape people's moral and ethical choices; and what they expect from social institutions, as well as how to broaden the base of involvement by community people and paraprofessionals in the delivery of health care.

Persons interested in such questions are invited to contact him.

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AN EXPLORATION OF POSSIBLE NEW DIRECTIONS FOR A CAMPUS MINISTRY

Submitted by

Leslie J. Atkinson, M.A.

My plans for the fellowship period were to pursue an interdisciplinary program of independent reading and class work focusing on medical ethics, value issues in medical education, health care delivery, and social policy at the University of Southern California. At the end of the fellowship period, I can safely say that the end result was an experience with many positive aspects and some negative ones.

My plans called for me to spend the month of August and the first part of September working with Dr. Wesley Robb of the School of Religion at USC who was offering a course in medical ethics for 15 undergraduate premedical students in the fall semester. This was to be the first time this course had been offered. Our original purpose had been for me to help him identify issues and literature which applied to medical - ethical problems. I had been looking forward to this, as it would have given me an opportunity to do a disciplined approach to reading in this area.

However, before this process really got under way, we found ourselves side-tracked on a philosophic tangent, namely, the identifying and labeling of the philosophic assumptions and methodologies under which medical ethicists work. Part of the motivation for this was the feeling that medical ethics or bioethics is so new a field that its major methodologies and assumptions are undefined. Part of Dr. Robb's concern is that in the lack of a well-defined methodology, people will unconsciously use an "old" one. Furthermore, he was interested in what corrective positivism could provide, if any. Needless to say, this turned out to be a much greater project than could be resolved in a six-week period; therefore we are still working at it.

I had also hoped to utilize this period of time to begin meeting with Dr. William May, also a member of the School of Religion, who is a member of the committee on research at the School of Medicine. He suggested the possibility of my sitting as an observer with the Committee, a possibility which I quickly pursued by a formal letter. Scheduling conflicts precluded our getting together during that period, and as it turned out, the Committee was extremely reticent about my being an observer to their deliberations. They argued confidentiality on the one hand - which I could understand - and the fact that I was not "administratively responsible to USC" on the other - which I could not understand. I found the inability to meet with the Committee on research to be a great disappointment inasmuch as I had really looked forward to seeing how it functioned.

Recently, however, some things have begun to happen with that Committee which may suggest some rather exciting possibilities for the near future. Dr. Alvan Rudisill, the University Chaplain who is also a member of that Committee, has told me that the Committee may be at a point where it recognizes that its ethical grounding and procedures are not as strong as they could be, even with the presence of Dr. Rudisill and Dr. May on the Committee. He is exploring the possibility of my sitting in as a process observer to help them keep track of how they function as a group and how they come to the decisions they do. He feels that my background in social ethics in addition to some work I have done in organizational development and conflict management might stand me in good stead in this instance. This proposal is still in the negotiating stage at the present time.

The beginning of the fall semester forced me to set aside these two projects and turn to the classes and reading program which I had laid out for the fall. Here again, they turned out slightly different than had been anticipated. I found that they formed an interesting and challenging trilogy which was probably more important for me personally in the long run than I had originally envisioned. As I stated before, I had hoped to focus on value issues in medical education, health care delivery, and social policy. The question of value qualification came out as a by-product rather than as an implicit end result; health care delivery was never implicity dealt with, because an anticipated course in "ethnic determinants of illness" never developed; and social policy came in the back door of two courses. What did develop was what amounted to a tri-partite examination of the individual-society dialectic. Let me attempt to explain this.

One course was a "Seminar in Corporate Responisibility" with faculty from the schools of Religion, Business, and Law. This course began with an examination of several theories and understandings of responsibility in order that we might develop a theoretical understanding for moving on to look at responsibility in business corporations and political organizations. Then the subsequent sub-sections were given over to specific theoretical discussion, followed by fairly extensive case studies of business corporations and political and governmental organizations.

The last small section of the course, but of most importance to me, was given over to voluntary organizations. Among the organizations classified as voluntary organizations were the church and professional groups such as the American Medical Association. This gave me the opportunity to engage in a fairly extensive study of the AMA and the politics of American medicine, and how pervasive that organization's influence is with regard to both health care delivery and policy setting. Thus, this was one of the courses in which social policy came in the back door. This course also introduced me to John Rawls and his theory of justice, which I found personally very exciting and satisfying. It is a concept that I feel a need to pursue in greater depth at a later time. This course came down heaviest on the corporate-societal side of the individual-society relationship.

The second course was a directed reading course in "Religion and Social Change." It dealt specifically with the question of the relationship of religion to society: namely, was its role to stabilize society or to provide the dynamics for change? In terms of Emile Durkheim, this was translated into a concern for the individual and how he integrated into society. In terms of Max Weber, it was a question of how to allow the new to break through and transform societal structures. This dialectic between the individual and society was pursued from Durkheim and Weber through the writings of Ernst Troeltsch, H. Richard Niebuhr, Peter Berger, Thomas Luckmann, and Robert N. Bellah. This pronounced dialectic of individual vis-à-vis society was never resolved in favor of one side or the other, but remained a constant reminder of the necessary tension between the two. As a result, it was the perfect course to stand as a balance between the "Seminar on Corporate Responsibility" and the third course, "Bio-technology and the Law."

This latter course, taught in the School of Law to second- and third-year students, was extremely challenging. It is a relatively new course which is still very much in the process of evolution and maturation. The first challenge of this course was the learning of an entirely new vocabulary and way of thinking. As such, it served as a reminder to me how easy it is for any discipline to develop a jargon and mind-set which are difficult for outsiders to understand. For me this was a cram course in constitutional law, especially as applied to individual rights and protections. It had an extremely heavy emphasis on inmate populations (e.g., prisoners and mental health patients), inasmuch as most of the cases we studied were concerned with individuals in these kinds of settings.

I found this to be a narrow and confining focus, and therefore was personally disappointed. The course did not get into public policy except through a few extremely indirect references, nor did it relate the legal structure to on-going health delivery programs. I had hoped that the constitutional analysis could have been extended to developing some bases for larger groups and the establishment and provision of health care programs. What did arise time and time again was the question of informed consent and the problem of coercion in all its varied forms.

This focus on the individual was an important and necessary thrust, and served as a counterbalance to the heavier emphasis on the societal side of the individual - society question of the other two courses. All this should not hide the fact that the reading materials were excellent for the breadth and depth of the technical data presented for background materials, nor the fact that the cases presented for study had a quality of realism about them, inasmuch as they came out of actual legal situations.

In summary, the fall semester was an exciting, challenging, stimulating, satisfying encounter. The greatest understanding I achieved through this period of study and reflection was a personal one, a self-discovery as it were, rather than professional competency. As I stated above, the fall semester turned out to have a real focus on the questions of the individual's relationship to society. As a result of that exposure, I discovered that I had been concentrating almost exclusively on the corporate-societal aspects, often losing sight of the individual. The fall experience has forced me to be more aware of the individual and his situation within the larger social setting.

Translating this concern into the professional realm means that I also have become very concerned about the question of informed consent, and what it is that the medical person thinks he is telling the patient-client-recipient, and what it is that the latter thinks he is hearing and understanding as a result of that exchange. This, then, ties in with one of my earlier concerns: the problem of value conflicts in social institutions. This, in turn, ties in with Dr. Rudisill's proposal for my involvement with the Committee on Experimentation at the University of Southern California School of Medicine. I do plan to explore at greater length the question of what informed consent means with respect to control groups in experimental groups.

In addition to clarifying my understanding of the relationship between the individual and society, the fellowship period was also useful in helping me to understand a little more fully the following: (1) the medical-political power structure and how it operates; (2) how religion functions socially, and therefore how it can be used as a conserving, stabilizing force or fulcrum for change; and (3) the many hidden legal traps a physician can fall into. A course in medical malpractice law would be very useful in helping to tighten up my understanding of this last category.

The effects of this fellowship period can go several ways. As a result of my being away and having dropped the accumulation of many activities, several things are being posed by a number of different people and agencies. The one thing that can be said is that whether as a campus minister or in some other capacity, my future professional plans call for me to become almost exclusively involved with medical education and health care delivery. Those in the religious community are posing one set of options, while those in the academic community are posing some others.

One possibility, which has been slowly developing, is for me to serve as a state-wide resource person for ministry to medical education in the State of California. To date, I am the only campus minister with this interest, and the number of schools with professional academic ethicists on their faculties are very few. Only a few offer any work in values. This would involve keeping the campus ministry staff apprised of issues and relevant literature to help them raise certain kinds of questions in the event that they are not being raised by some other person or agency. There is a group of campus ministers in the state who have been concerned with the whole area of Higher Education and Public Policy. During the past few years, they have been very involved with the legislative committee that is working on the revision of the Master Plan for Higher Education in California. They are now prepared to expand their focus to deal also with the question of health care education and delivery.

Another possibility posed by the religious community is for me to serve as a bridge between the medical-academic community and the religious community. One reason for this is that both communities have a concern for healing and wholeness, but at the present time seem to do very little talking to each other. One option here might be to begin some kind of continuing education program for health care professionals who are church members.

It is interesting that some faculty in our medical school are also talking about my functioning in some kind of bridging-catalytic capacity. More concern about the lack of interdisciplinary conversation has been expressed this year than during the previous six years. There have been the usual cries of not having enough time to keep up with one's own discipline, much less the significant work in another area. A number of individuals have expressed the hope that I might prove to be the catalyst who brings about some of this interdisciplinary conversation.

Some of the same people are hoping this will lead to a more explicit curriculum offering, either in terms of a class or classes, with the possibility of some kind of program further in the future. They are encouraging the development of a split academic appointment, teaching social ethics to undergraduates and medical ethics to medical students. This latter possibility is one which has just been proposed by some faculty, and is only in the very beginning stages of thought and development.

Whichever of these possibilities finally materializes, I fully intend to pursue the matter of informed consent mentioned above.

At the present time things are too much in flux to make any definite proposals about new courses. However, last spring Dr. Robert N. Livingston and I collaborated on a very low key one-unit seminar on "Moral and Ethical Problems in Medicine." It was an extremely unstructured class. Now we are talking about how we can give that class more structure and more continuity. My experiences of the fellowship period will feed into whatever we do in that class.

Other studies and activities I would like to undertake in the future depend on the resolution of a major question about my situation: whether or not the denominations and agencies which support my campus ministry work will view my focusing on medical education as a high priority item or as a luxury they cannot afford. In whatever way this issue is resolved eventually, my personal plans call for continued involvement with medical education and health care delivery in some way.

ABBA E. BOROWICH

Born in July 17, 1942, the second of two children in a modern orthodox Jewish family, I was raised in New York City's Lower East Side. In my formative years and through college, there was considerable emphasis in my education on traditional Jewish culture, literature, ethics, and theology. I attended the Rabbi Jacob Joseph Elementary and High Schools in New York, the first major Jewish traditional day school to be established in the United States. My premedical studies were undertaken at Yeshiva College, New York, where I was the recipient of the Talmud Award in my junior year, and received a B.A. degree in 1963. In keeping with my current career goals, it was most fortunate that as an undergraduate I was able to take a course in Jewish Medical Ethics conducted by Rabbi Dr. Immanuel Jakobovitz, currently the Chief Rabbi of Great Britain.

My medical training was at the State University of New York, Upstate Medical Center, Syracuse, New York, from 1963 to 1967, where I was further exposed to the issues of medicine and human values through my contact with Dr. Thomas Szasz, Professor of Psychiatry. Although some of Dr. Szasz' views are controversial, the elective periods spent with him further stimulated my interest in the quality of patient care. While a medical student, I also was awarded several fellowships from the National Institute of Mental Health which enabled me to gain clinical experience in psychiatry. After receiving my M.D. degree in 1967, I served one year as the first psychiatric intern at Roosevelt Hospital in New York City. I then spent two years at the National Institute of Mental Health - Clinical Research Center in Lexington, Kentucky, and participated in the revision of their program from a prison-like atmosphere for voluntarily committed narcotic addicts to that of a therapeutic community.

In July, 1970, I began psychiatric residency training at Mount Sinai Medical Center in New York. From 1971 to 1972, I served as Chief Resident in Psychiatry at the Hospital, as well as Assistant in Psychiatry, Mount Sinai School of Medicine, City University of New York. In this capacity I was able to initiate a program concerned with human values in medicine. Previously the students and residents had been given little or no training in this area, and few had been stimulated to think along humanistic lines. From 1972 to 1973, I was appointed Senior Chief Resident and Instructor in Psychiatry, Mount Sinai School of Medicine, City University of New York. This heretofore non-existent position was created to afford me the opportunity to participate more actively in the teaching program of the Department of Psychiatry, during which time I expanded the number of seminars in medical ethics for second, third, and fourth-year students.

During the second year of my psychiatric residency, I carried out a study on patient and staff reactions to several suicides by staff members. This investigation included a consideration of a variety of aspects of human values related to suicide. The paper, entitled "Psychiatric Staff Suicides: A Taboo Subject?" was presented at the 126th Annual Meeting of the American Psychiatric Association in May, 1973. This paper describes the preliminary results of the study; further analysis of the data will be published in the future. During my third year I also was engaged in a study designed to determine how the attitudes of the staff and patients on the in-patient psychiatric units of the Mount Sinai Medical Center may affect the quality and outcome of treatment the patients receive.

My residency training was completed in June, 1973, and I was deeply honored to be awarded the M. Ralph Kaufman Award of the Mount Sinai School of Medicine as the outstanding graduating psychiatric resident.

Upon the completion of my residency, I was appointed an Associate in Psychiatry at the School of Medicine, and became the Associate Director of Psychiatric Ambulatory Services at the Mount Sinai Medical Center, with the hospital rank of Senior Clinical Assistant Psychiatrist.

During my tenure as an Institute Fellow, I was fortunate to have been appointed to membership on the Ethics Committee of the American Psychiatric Association-New York District Branch, being the youngest and first non-former president of the Branch to be appointed. Membership in this Committee has enabled me to begin to apply the many theoretical ethical aspects learned during the course of my Fellowship study to the practical ethical decision-making focus of the Committee.

Further application of my Fellowship study will take place this summer when my wife and I will participate in the 1974 Summer Institute for Cross-Disciplinary Teaching and Research on the subject of "Formation in Professional Identity" at Williams College, sponsored by The Society for Religion In Higher Education.

On a more personal level, I am married to Sandra (neé Horowitz), and am the father of four-year-old David Eric and two-year-old Jillian Sheryl .

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STUDIES IN THE RELATIONS BETWEEN PSYCHIATRY, LAW, SOCIOLOGY, AND HEALTH CARE

Submitted by

Abba E. Borowich, M.D.

> "It is the duty of all persons, when affairs are the most prosperous, then in especial to reflect within themselves in what way they are to endure adversity."
> Terence (185-159 B.C.)
> Phormio. Act II, Sc. I, Line 11

The words of Terence express all too clearly what should have been on my mind upon my being notified of my Fellowship grant. For, very soon thereafter, I was notified by my preceptor in the sociology of health care, Dr. Emily Mumford, that because of unforeseen circumstances, she was leaving the Mount Sinai School of Medicine and could therefore devote very little time to my work. Shortly after that, Dr. Harold Edgar, my preceptor in law at the Columbia University School of Law, informed me that various logistical problems had forced the cancellation of one of the courses I had planned to take at the law school, and that the other two had to be shifted to the spring semester. In addition, one of the law professors began to express some trepidation at the thought of a graduate psychiatrist being present at a course he was teaching for the first time in "Law and Psychiatry."

During this inauspicious beginning, I can now state in retrospect that I endured and prospered. Dr. Mumford was kind enough to devote enough time to me before her departure to point the way to many interesting and valuable sources regarding patient compliance to doctor's orders, and to the determinants and measurements of values inherent in the health care system. I drew primarily from the work of Adorno, Rokeach, and Sorinoff in attempting to find a reliable and valid instrument for the measurement of authoritarianism within the physician-patient interaction, and am presently reviewing my preliminary results to see if this measurement will have any predictive value on the course of treatment in the Medication Clinic of the Psychiatric Outpatient Department.

The highlight of my Fellowship period, though, was my study at the Columbia University School of Law. The two courses there were more valuable than I had anticipated, and were intensely stimulating, broad-ranging, and delightful. "Law and the Life Sciences," led by Dr. Harold Edgar, Associate Professor of Law at Columbia and a Hastings Society

Fellow, and Dr. Willard Gaylin, the Hastings Society President, was predominantly theoretical and philosophical. In contrast, "Law and Psychiatry," led by Columbia Law Professor Jack Himmelstein and Dr. Robert Michels, the new Chairman of the Department of Psychiatry at Cornell Medical School and a Hastings Fellow, proved to be more practical in orientation.

"Law and the Life Sciences" emphasized multi-disciplinary readings in such areas as genetic engineering, death and dying, behavior and population control, transplantation, and human experimentation. It was especially noteworthy because the participants in the seminar came not just from the law school, but from the Columbia College of Physicians and Surgeons as well as from the Woodstock, Union, and Jewish Theological Seminaries. Multi-disciplinary groups were also created to draft legislation in the various areas studied, and then to defend the legislation in class. Having previously been an outspoken critic of much of the existing health care legislation because of its vagueness and imprecision as well as its narrowness of focus, I was somewhat chagrined to find the drafting of such legislation to be such a humbling experience. It became clear to me that, for instance, the seemingly effortless legitimation of the widespread practice of passive euthanasia via statutory reform was a rather monumental step in its theoretical, practical, and especially philosophical ramifications. It should also be noted that Dr. Edgar and Dr. Gaylin are masterful pedagogues whose ideas I plan to borrow liberally in my own teaching at Mount Sinai.

The "Law and Psychiatry" course dispelled other illusions I had had about the law, as well as about psychiatry. I had previously thought that law and psychiatry were really analogous disciplines applying reason to the understanding and regulation of human behavior. I was rather surprised to see the enormity of the differences between the two disciplines, especially regarding philosophical orientation and a priori value assumptions. In addition, after participating in the preparation of several cases for "moot court" exercises, I recognized the practical necessity of having a good lawyer should my presence in a real court be required in adversary proceedings.

There were other noteworthy activities that related directly to my Fellowship:

(1) Through the intercession of Dr. Kurt Hirschhorn, the Director of the Department of Medical Genetics at Mount Sinai and a Hastings Society Fellow, I was able to attend two weekend-long task force meetings of the Hastings Center -- on Behavior Control and Genetic Engineering. While I felt like an interloper in the first meeting, Dr. Hirschhorn's presence facilitated my smooth entry into the session on genetics, and it proved much more valuable to me both in terms of my contributions to the meeting and their sequelae and in terms of what I learned from it.

The immediate sequelae of the genetics meeting were:

(2) Invitations to lecture to the Departments of Pediatrics and Genetics at Mount Sinai which, in turn, led to invitations to participate in the "Introduction to Medicine" course for first- and second-year medical students. Other invitations have led me to talk to the senior class of the Fieldston School in New York and to members of the house staff and faculty at Mount Sinai (other than the seminars I had continuously led in medical ethics). In addition, I was recently invited to talk to the students of the Polytechnic Institute of New York.

(3) My time was freed sufficiently, through the Institute's support, to develop liaisons with the patient ombudsman at Mount Sinai as well as with the Departments of Genetics and Community Medicine. These liaisons will hopefully lead to the development of an ongoing study group in human values and medical ethics at the Medical School.

In addition, acquaintances were developed with a number of the Fellows and Associates at the Hastings Society and the Horizons program at the Riverside Church in New York City. I hope to be able to draw on the talents of some of these people as the teaching program in medical ethics at the Medical School begins to define itself further.

(4) As a direct result of my Fellowship, I was invited to participate in the 1974 Summer Institute for Cross-Disciplinary Teaching and Research on the topic "Formation In Professional Identity," sponsored by the Society for Religion in Higher Education. This intensive three-week workshop will focus on an issue that has been an interest of mine since my study with Dr. Thomas Szasz in medical school. With some luck, I hope to be able to continue this work if accepted for inclusion in the Hastings Society study on the role of the psychiatrist in society.

(5) Finally, the annual meeting of the Society for Health and Human Values in Washington, D.C. and the Sugar Loaf meeting, especially, were particularly valuable. Sharing ideas and experiences with other Institute Fellows gave further impetus to work that, all too frequently, seemed like a lonely, uphill battle.

RONALD A. CARSON

Ronald A. Carson, a native of Indiana, has studied at institutions in the United States, Germany, and Scotland, and is a graduate of Franklin College, Colgate Rochester Divinity School, and the University of Glasgow. Having done field work at the Atlantic Avenue Baptist Church in Rochester, New York, and as assistant to the chaplain at the University of Rochester, Dr. Carson served as Senior Fellow and Dean of Studies at Mark Hopkins College in Vermont before joining the faculty of the Division of Humanities at New College, Sarasota, Florida, as a professor of religion in 1969. During 1972-73 he designed and implemented an experimental undergraduate summer program at New College.

Dr. Carson has an abiding interest in the craft of teaching, and has collaborated with colleagues in social psychology, history of religions, and philosophy in the design and implementation of seminars which resist categorization in any one of the traditional academic disciplines. Within his own discipline (theology and culture), his specific interests are Christology and ethics. Outside his discipline, his interests exist on the boundaries between theology and a number of the social sciences, particularly psychology, and between theology and literature.

Dr. Carson was the recipient of the University of Glasgow's Postgraduate Fellowship in Divinity for 1965-68. During the fall semester of 1966, he undertook research at the Nietzsche Archives in Weimar at the invitation of the National Research Institute of the German Democratic Republic. His current research in the field of health and human values is being supported by a post-doctoral fellowship from the Institute on Human Values in Medicine of the Society for Health and Human Values, and by a grant from the Council for Philosophical Studies.

In addition to book reviews in such periodicals as The Christian Century and the Journal of the American Academy of Religion, Dr. Carson has published a long monograph on Sartre, and articles and occasional pieces on Nietzche and Kurt Vonnegut. His most recent article, "Amidst Children and Witnesses: Reflections on Death from a Theological Perspective," appeared in the Winter, 1974, issue of Duquesne University's journal, Humanitas.

Dr. Carson is married and is the father of two daughters.

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PARTICIPATION IN AN EXPERIMENTAL PROGRAM RELATING HUMANISTIC STUDIES TO A PREMEDICAL CURRICULUM

Submitted by

Ronald A. Carson, Ph.D.

When, approximately one year ago, I made application to the Institute on Human Values in Medicine for a fellowship, I wrote that the fellowship would enable me to participate in the Experimental Program Relating Humanistic Studies to the Premedical Curriculum at the University of Florida, winter and spring quarters, 1974. In retrospect, the grant has made it possible for me to take part in that program and, in addition, to do much more which could not have been anticipated a year ago. I shall first describe the program, and then attempt to say something about the other activities in which I have been involved.

The Experimental Program Relating Humanistic Studies to the Premedical Curriculum consists of two seminars designed to provide a coherent humanistic context for the academic experience of premedical students. The program is so structured that it brings together teaching faculty and material for study from a variety of academic disciplines in a genuine cross-disciplinary fashion. In the first segment of the two-course sequence, attention was given to humanistic values and methods of inquiry within selected health-care settings--a community mental health service, an extended health-care facility, a rural health-care center, and an inner-city hospital. The emphasis in this course offering was predominantly clinical. In the second segment, multiple perspectives were brought to bear upon thematic materials from a single discipline in an offering titled "Literary Definitions of Life and Death.

The "other activities" to which I referred above are more difficult to describe because of both their various-ness and their richness. In effect, I became apprenticed to Dr. Sam A. Banks of the Department of Community Health and Family Medicine. For approximately 1½ days per week during the winter and spring quarters, I listened to Dr. Banks, questioned him, took part in a variety of his classes, developing in the process a composite of the skills requisite to the craft of teaching medical students from a humanistic/social scientific/behavioral perspective. In addition, I interviewed faculty members and administrators teaching in or responsible for such programs as Allied Health, Physician Assistant, and Family Practice Residency, soliciting from each of the persons interviewed suggestions for readings that would broaden and deepen my knowledge of their field or program.

Before becoming a Fellow, my experience with what has come to be known as "health and human values" had been meager, and my exposure to tertiary health care and the teaching of medical students nil. During the final year of my undergraduate career, I had worked as a night orderly in a small county hospital. Through participation in courses in pastoral psychology as a graduate student, I brought a theoretical component to my first-hand experiences on the wards and in the emergency room. As a teacher of undergraduates, I then began to build upon my experience and training by preparing and teaching a seminar called "Death, Grief, and Dying" (1972), and by serving as a consultant to a summer workshop on aging and dying sponsored by the Public Programs Division of the National Endowment for the Humanities (1973). Shortly before commencing my work as a Fellow, I completed work on an essay, "Amidst Children and Witnesses: Reflections on Death from a Theological Perspective," published in the winter issues of Duquesne University's journal, Humanitas.

As a result of my experience as a Fellow, my interest in health and human values has been both heightened and focused. Currently, I and a colleague in philosophy are teaching a course of our own design on "Aspects of Medical Ethics" to undergraduates. (A reading syllabus is attached.) There is faculty and student interest and administrative support for developing a program in this area at New College, and if sufficient funding can be found, I intend to be instrumental in designing and implementing such a program. In any event, my own professional activity will continue to be substantially related to the area. (During the summer of 1974 I shall participate in The Council for Philosophical Studies' summer institute on "Moral Problems in Medicine" at Haverford College.) Upon completion of my Fellowship period in June, I intend to prepare a position paper on teaching from a humanistic perspective in a health-care setting.*

I am interested in hearing from others working in the area.

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* Editor's note: Because this report was printed prior to the completion of Dr. Carson's tenure as an Institute Fellow, his fellowship activities cannot be described fully at this time. Additional information will be available later.

ASPECTS OF MEDICAL ETHICS

Dr. Carson & Dr. Norton
Term III, 1974

1. HUMAN VALUES AND THE SANCTITY OF LIFE

Hans Jonas, "Technology and Responsibility: Reflections on the New Task of Ethics"
Daniel Callahan, "The Sanctity of Life," including the three commentaries and Callahan's response, in Cutler

2. MODELS AND MAN AND ETHICAL MODELS

Reinhold Niebuhr, The Nature and Destiny of Man, vol. I, Ch. 1.
S. I. Benn & R. S. Peters, Principles of Political Thought, Ch. 2.
Joseph Fletcher, "Indicators of Humanhood: A Tentative Profile of Man," Hastings Center, November, 1972.

Justice

Immanuel Kant, Fundamental Principles of the Metaphysics of Morals
John Rawls, "Justice as Fairness"

3. MODELS OF MAN AND ETHICAL MODELS (continued)

Utility

John Stuart Mill, "Utilitarianism"
A. C. Ewing, "A Critique of Act Utilitarianism"
John Rawls, "Two Concepts of Rules"
C. L. Stevenson, "The Nature of Ethical Disagreement"
Alan Gewirth, "Positive Ethics and Normative Science"

4. THE CONCEPT OF HEALTH: PHYSICAL

David Mechanic, "Health and Illness in Technological Societies"
M. Siegler & H. Osmond, "The 'Sick Role' Revisited"
Robert M. Veatch, "The Medical Model: Its Nature and Problems"
Daniel Callahan, "The WHO Definition of Health"
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5. THE CONCEPT OF HEALTH: PSYCHOLOGICAL

Ken Kesey, One Flew Over the Cuckoo's Nest
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Peter Sedgwick, "Illness--Mental and Otherwise"

6. ABORTION

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10. THE EDUCATION OF THE PHYSICIAN-INVESTIGATOR

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BRUCE R. DITZION

Born in 1941, Bruce Ditzion was educated in the New York City public schools. He received his A.B. degree from Alfred University and the M.D. degree from the Albert Einstein College of Medicine. Dr. Ditzion completed a medical internship and residency at the Peter Bent Brigham Hospital in Boston, and is a Diplomate of the American Board of Internal Medicine. From 1967 to 1969, he was a research associate in pharmacology at the National Institutes of Health. Work there in biochemistry and pharmacology resulted in a number of publications.

Since 1970, he has been associated with the Harvard Medical School Family Health Care Program. This change in career direction from basic research into primary care was motivated by an increasing interest in the social implications of medicine. He is now engaged in the practice of primary care medicine, as well as the training of medical students and residents in comprehensive care.

In both the practice and instruction of this kind of medicine, nonmedical problems are constantly present. Often, the family medicine course is the only chance in medical school that students have to evaluate their performance when faced with these issues. In order to develop a broader perspective, a study fellowship (supported by the Institute on Human Values in Medicine) was undertaken in medical sociology.

Dr. Ditzion and his wife live in Cambridge, Massachusetts. They are expecting their first child in the near future. His wife, Joan Sheingold Ditzion, has been active in women's health education. She is a member of the Boston Women's Health Book Collective, and is a co-author of Our Bodies, Ourselves, a widely read book.

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EXPLORATIONS OF "BOUNDARY ISSUES" IN PRIMARY MEDICAL CARE

Submitted by

Bruce R. Ditzion, M.D.

I spent one half of my time between October 30, 1973, and April 30, 1974, working on the fellowship project. The other half was devoted to my teaching and clinical responsibilities at the Harvard Medical School Family Health Care Program. The fellowship time basically consisted of a program of reading in general sociology, anthropology, and medical sociology, with discussions of this material with Professor Mark Field of Boston University. I prepared a paper, "Boundary Issues in Primary Medical Care: The Limits of Professional Responsibility," which is based upon these readings, as well as my clinical and teaching experience. Discussions of these issues were also held with members of our program's staff, as well as other members of the Boston-Cambridge medical and academic community. These activities were planned for at the time of my application, which was for a six-month full-time fellowship. Since I was funded for only a six-month half-time period of study, I was forced to limit the scope of efforts. I decided not to enroll in the three courses at Harvard that were part of my original plans, but rather to concentrate upon an independent study and reading program.

My understanding of boundary problems was greatly increased as a result of my readings. The time that was made free from my usual responsibilities also allowed me to develop some perspective on my work in primary medical care. I was profoundly impressed by the relevance of work by such sociologists as Talcott Parsons and Eliot Freidson to the confusing mixture of medical and social problems which are presented by our patients. Particularly important are their descriptions of doctor-patient relationships, professional roles, and the relationship of the medical profession and society. My present thinking about these issues is discussed in the enclosed statement. Medical sociology appears to have made little impact on medical education or practice. Reasons include the dominance of medical education by scientific and technical considerations, as well as the political failure of social scientists and humanists to gain a foothold in the medical schools. Further pursuit of boundary issues--at both a conceptual and empirical research level--is a much-needed cooperative effort between the humanities and health professions.

The development of my thinking in the ways I have just described has improved my effectiveness as a teacher. I am convinced that my students learn more about the boundary issues that arise in their patient care work, if the experiences can be put into social perspective. I believe that my own effectiveness as a clinician has increased as a result of the fellowship. My skills in helping people with life-style, psycho-social, and compliance problems have improved since I have had the opportunity to evaluate the problems, therapeutic goals, and my own behavior as a physician.

Boundary Issues in Primary Medical Care: The Limits of Professional Responsibility*

by Bruce Ditzion, M.D.

Physicians are constantly confronted with issues that go well beyond the scope of organic medicine that they were taught in medical school. Boundaries and linkages between non-medical and medical issues will be discussed as they pertain to medical education and practice. Care of the "total patient" almost always requires some consideration of matters on both sides of the boundary. Of interest to this investigation have been the kinds of cases in which the non-medical elements are of overwhelming importance--instances in which social, cultural, and psychological aspects are central to the problems for which the patients request help.

Medicine is a helping profession, and people consult their physicians with a variety of needs. The physician's mandate of helping may be inconsistent with his or her patients' needs because (1) the problem falls outside the perceived scope of professional responsibility and expertise, or (2) the problem (even if it is within the physician's area of interest) cannot be helped. Areas of responsibility can be understood according to a system which categorizes problems. Talcott Parsons has described modern society as being made up of our major sub-systems--social, cultural, personality, behavioral organism--each of which functions to maintain stability and achieve major goals. For purposes of the medical care process, dimensions can be outlined according to Table I.

Dysfunction of individuals can fall into any or all of these dimensions. Positive change, if it is to occur in such cases, requires alteration in each malfunctioning system. Many people with biological problems, for which curative or ameliorative techniques exist, cannot be helped because of non-compliance with diagnostic treatment measures caused by social, cultural, or intra-psychic issues. Professional role definitions are important in determining how the physician will react to a multi-dimensional problem. The emphasis upon technical--rather than personal--variables is characteristic of our highly specialized medical care system. Many physicians limit their involvement with patients to problems which are perceived as "strictly medical." This aspect of the physician's role is typical of those who perform specialized work elsewhere in modern, industrialized society.

Many non-medical issues which are, in fact, dealt with by the medical profession are defined as medical. An example of this phenomenon is the field of "mental health." Moral, legal, economic, political, and social problems have been included under this umbrella. Such an orientation legitimizes a humanistic view, but tends to negate the concept of free will and the individual's responsibility for his own actions. Furthermore, it may facilitate measures that curtail freedom and civil liberties through the denial of rights to the "mentally ill" persons. The person who has brilliantly defined and articulated these issues is, of course, Thomas Szasz.

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*This report is a preliminary summary of work in progress.

Although broadening the physician's role carries implicit dangers, a narrow role may preclude the possibility of helping many individuals in need. This polarity can be thrown into focus by examining the issue of compliance. A large number of patients with organic diseases, for which good methods of prevention, control, or cure are available, are not being helped because of issues outside of traditional medical boundaries. An example is hypertension, a serious chronic disease that afflicts twenty-three million Americans. Fewer than twenty-five percent of hypertensives are receiving any treatment at all, and much of that treatment may be inadequate. A major reason for this failure is the lack of compliance on the part of patients who are put on long-term drug regimens for this condition. In the landmark Veteran's Administration Cooperative Study that established the efficacy of anti-hypertensive drug treatment in preventing stroke, congestive heart failure, kidney failure, and accelerated hypertension, one-half of the patients failed to keep doctor visits or to take pills. Table II outlines reasons that a given patient might not comply with a treatment regimen. If advances in biomedical technology (such as the development of simple and efficacious means of preventing complications of hypertension) are to be translated into benefit for patients, attention must be given to related non-medical issues.

The definition of the physician's role also comes into question in view of the close relationship between lifestyle, morbidity, and mortality. In looking at questions of preventive medicine, the relationship is quite dramatic. Table III outlines potential mortality risks for a forty-year old white male. Preventive medicine should involve assessment of these risks and health education about the relationship between lifestyle and disease. Effective prevention must, by definition, extend beyond narrowly defined biological limits.

The above discussion of lifestyle-related illness and patient cooperation in medical care describes non-medical factors that are crucial to the physician's classic role in the prevention and cure of organic illness. Hazards of an excessively specific approach were outlined. An even more significant issue in medical care concerns the large numbers of medical patients who present psycho-social problems to their primary physicians. One indirect index of the extent of this phenomenon is the extraordinary rate of psychotropic drug prescriptions in the United States. It is estimated that twenty-five per cent of the adult population are prescribed psychotropic drugs at some point within a year.

The degree to which the physician and patient describe the physician's role as a social or medical agent greatly affects the interaction that occurs around psychosocial problems. Medical ideology will result in problems of living being treated chemically. Mislabelling social problems as "medical" (thereby subject to biological diagnosis and treatment measures) is counterproductive. Depending upon one's orientation and position about the medical-social boundary, the outcome of the doctor-patient interaction may dramatically vary.

Medical education in the classic Flexner model has largely ignored boundary problems. There is some hope that with the development of teaching programs in community medicine and family medicine, these issues will be given some attention. Trainees will need to gain experience in longitudinal comprehensive care, which exposes them to patients who are never diagnosed, cases in which first judgments are later proved wrong, problems in negotiating long-term doctor-patient relationships, and issues of lifestyle and compliance. This kind of training requires time, and must necessarily compete for curriculum space with other disciplines.

Involvement by well-meaning physicians in boundary issues provokes some thorny dilemmas. Szasz has eloquently described the drawbacks of the humanitarian-motivated redefinition of problems of living as "mental illness." One danger of professional involvement in boundary problems is that this can result in the values of a physician being imposed upon the patient. Such a process is incorrectly justified on the authority of "scientific knowledge" not subject to dispute (especially by non-experts). However, extension of the scope of professional responsibility carries the advantages illustrated by the discussion of compliance and lifestyle.

Physicians tend to adhere to the value structure of the particular segment of society from which they come. Doctors hold a great deal of authority in many doctor-patient relationships. The amount of authority varies with the type of relationship, but imposition of the physician's values upon patients is a constant possibility. Awareness of these possibilities by both physicians and their patients should provide some protection against abuse of authority. No perfect resolution exists for this problem. Advantages and risks must be weighed and reconciled in order to establish the merits of physicians' involvement in particular cases.

TABLE I

Dimensions	Components
Social	Family Structure, Legal System, Political System, Economic Structure, Occupational Structure, Medical Care Structure
Cultural	Values, Goals, Superstitions and/or "Common Sense" Folk Beliefs, Ideologies
Psychological	Cognitive and Affective Functioning of the Individual
Biological	Physiological and Pathological Processes

TABLE II

Dimensions	Reasons for the Failure of Patients to be Adequately Treated for Hypertension	
Biologic	Disease too severe to be adequately controlled by current measures	
	Side effects of medication cause patient and/or physician to discontinue medication	
Intra-psychic	Non-compliance caused by:	Low intelligence
		Psychosis
		Depression, low self-esteem, self-destructive impulses
		Fear of diagnosis with heavy use of denial
Cultural	Non-compliance caused by:	Patient's lack of understanding of diagnosis and treatment regimen (reflects deficiencies in general health education as well as specific doctor-patient interaction)
		Does not accept medical ideology (biological causation and treatment of disease)
		World view incongruent with accepting treatment for a non-symptomatic disease
Social	Lack of access to medical care (political-economic)	
	Non-compliance associated with:	Overwhelming pressures (e.g., family, economic problems) are a greater priority for the patient than attention to a problem that presents no immediate difficulties
		Inadequacies within the doctor-patient relationship

TABLE III

(WHITE MALES AGES 40-44) (1968 Statistics)

Rank	Cause of Death	Chance in 100,000 of the individual's dying from this cause in the next 10 years	Lifestyle-Related Precursors
1	Arteriosclerotic Heart Disease	1861	Obesity, Exercise Habits, Cigarette Smoking, Stress, Diet
2	Motor Vehicle Accidents	339	Mileage per year, Seat Belts Use, Alcohol Habits, Driving Habits, Depression, Drugs
3	Cirrhosis	304	Alcohol
4	Malignant Neoplasms of the Lung	291	Cigarette Smoking
5	Suicide	253	Depression, Drugs, Alcohol
6	Vascular Leions Affecting Central Nervous System	209	Obesity, Exercise Habits, Cigarette Smoking
7	Pneumonia	114	Cigarette Smoking
8	Malignant Neoplasm of Large Intestine and Rectum	88	
9	Homicide	87	Social and Economic Status, Drug Use
10	Rheumatic Heart Disease	87	
11	Accidents--Machinery Related, Non-Motor Vehicles	70	Occupation
12	Bronchitis and Emphysema	62	Cigarette Smoking
	Other Causes	1725	
	Total Causes	5490	

JAMES P. MORRIS

Born on September 11, 1943 at McComb, Mississippi, Morris received the B.S. degree from Mississippi College in 1965. He majored in zoology; minored in English and chemistry; and participated in various activities relating to music. For one year (1965-66) he attended the Louisiana State University School of Medicine. In the summer of 1966 he began graduate study in history at the University of New Orleans. He completed his training in history at the master's level in the spring of 1968, having worked as a graduate research assistant and teaching assistant, and received his M.A. from U.N.O. in 1969. Dr. Burton Ira Kaufman directed his thesis, entitled "Henry Cabot Lodge and Congressional Control of Foreign Policy."

Morris was awarded a Josiah Macy, Jr. Foundation Pre-Doctoral Fellowship in the History of Medicine and the Biological Sciences in the spring of 1968, to study under Dr. John Duffy at Tulane University. He entered the Tulane graduate history program that fall, and his Macy Fellowship was renewed from 1969-71. He served as a teaching assistant at Newcomb College, and a research assistant to John Duffy from 1971-72.

In August, 1972, Morris was appointed an Associate in the History of Medicine, Tulane University School of Medicine. Morris completed his Ph.D. in the Department of History in 1973. His area of specialization was United States social history, with concentration in the history of medicine and science. Dissertation topic: "Blood, Bleeding, and Blood Transfusion in Mid-19th Century American Medicine."

Morris now serves as Director of the History of Medicine Program, Tulane University School of Medicine. He lists the following areas of special scholarly interest and/or concern:

1. Teaching -- the personal and professional development of medical and public health students.
2. Changes in American medicine vis-a-vis American society.
3. The consideration of issues which reach a crisis level of concern in American society: specifically, "presentism" as a bias in the explanation of America's societal problems relating to medicine and health in the past, present, and future.

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SELECTED STUDIES IN THE HISTORY OF MEDICINE

Submitted by

James P. Morris, Ph.D.

As I had hoped, Dr. Chester Burns, Director of the Medical Humanities Program at U.T.M.B., ushered me through a series of learning experiences which fully introduced me to U.T.M.B.'s comprehensive approach to the medical humanities. One of the great strengths of the Galveston program is Chester Burns, because he has not hesitated to reach out to disparate elements, incorporating them as fundamental parts of the program. Burns' motto well might be: "When properly monitored, diversity need not be equated with a decline in scholarship."

The details of my participation in the exciting U.T.M.B. program can best be broken down topically.

1. History of Medicine - Naturally, since this was my specialty, I felt most comfortable in this area. I grew personally and professionally from our long talks about the rewards and difficulties of cultivating broad-based support for the history of medicine as a core scholarly discipline which has potential wide appeal, and from which many spin-offs in the medical humanities are possible.

In a more formal or structured sense of training, I found Burns uniquely qualified to guide me through his suggestions on the history of medical ethics. The great strength of his overview is its comprehensive nature. He has struggled and researched for years with concepts inherent in the term "history of medical ethics." He has assembled an impressive bibliography and card file. He will undoubtedly continue to make many contributions to the field. In fact, Burns should emerge within the next decade as the authority on the history of medical ethics.

Tracing ideas and refining concepts are tedious and sometimes frustrating. The eternal problems of low-brow vs. high-brow exist in any circumscribed area of study, flowing and churning brutally across any system the mind constructs. Without divulging any of Burns' hard-won concepts and suggestions on the subject, a few other general statements can be made. Explained in the broadest possible terms, he demands that the challenge of his subject is that it must be seen as a tedious picking out of relationships throughout medicine's past, on a sliding and fluctuating scale which involves as focus points: the physician, other health personnel, the patient, the public, the institutions of society. Burns fully recognizes that the great danger in this approach is that his subject could easily become -- like any comprehensive, social topic -- a huge history of medicine. Quite obviously, I believe Burns will prove a valuable consultant and resource as medical humanists continue to grow toward a consideration of past medical ideas on ethics as a significant and necessary pursuit.

2. Philosophy of Medicine - No matter how I express it, to say that being exposed to the ways of a medical philosopher was exciting is a gross understatement. I was continually challenged, and often overwhelmed. Perhaps the greatest joy of the month's study was the enthusiastic but patient way Dr. Tristram Engelhardt helped me understand the philosopher's role as a refiner of ideas. My most rewarding gains were due to Engelhardt's willingness to help me examine my own presuppositions, as well as those of my specialty, and their relation to teaching and research within both a medical center and a university. Also, I developed renewed respect as well as awareness of what today's physician-philosopher can contribute to other scholars as well as students in a medical setting.

My contact with Dr. Engelhardt as a scholar engaged in confronting some of the ethical issues surrounding medicine today proved stimulating. As examples, he is contributing to a redefinition of the meaning of the term "philosophy of medicine" through his frontal assault on such topics as personhood, psychotherapy, disease, abortion, and euthanasia. (I shall discuss this further below.)

Dr. Engelhardt is a scholar with enormous talents and skills, and a prodigious worker. He should emerge in the front ranks of work on human values in medicine, for he is reshaping the meaning implied in the term "philosophy of medicine." Therefore, the potential for his work's affecting all of the rest of us, in whatever specialty relating to a medical center, is mind-boggling.

3. Clinical Medicine - My exposure to clinical medicine proved exciting and rewarding. It renewed my acceptance of the term "physician" as implying a combination of the roles of healer and scientist. I knew the validity of this concept based on the past of medicine. In my exposure to clinical medicine at U.T.M.B., the same truths were apparent within the traditional hierarchal house-staff training system. In clinical conferences the residents were as sure and confident as the latest facts could make them. But of necessity they deferred to the senior clinicians in the nagging knowledge that what they presented as absolute would stand up only if they had used proper judgment in evaluating the hard facts.

I was guided in observing clinical medicine by Dr. Edward C. Larkin, Assistant Professor of Internal Medicine. My exposure to the scientific side of clinical medicine concentrated in the specialty of hematology, since one of my areas of historical research relates to blood. Then I observed and participated in a bedside clinical session with Dr. William P. Deiss, Chairman of the Department of Medicine, and a teaching unit of four medical students.

I also talked about a wide range of topics relating to the delivery of health care in American society with Dr. George L. Pauk, Director of the Clinics, Department of Medicine. In talking with Drs. Larkin and Pauk, I gained new awareness of not only the importance of preserving human concern and courtesy as common features of clinical contact with patients; I learned also that teaching in the medical humanities can have significant impact on the medical product which the sick patient receives through sensitization of students to keeping these goals in mind. Thus, the medical humanities need not appear to be an esoteric discipline. Rather, they can significantly ease the transition of America into whatever system of broader-based health care emerges in the seventies.

4. Medical Education - My interaction with Harold G. Levine, Director of Research in Medical Education, proved stimulating and fascinating. As a behavioral scientist, Levine emphasizes the end product of teaching efforts as the basic criterion for input all along the line. The importance of moving toward this approach was evident in the ongoing teaching program in the medical humanities at U.T.M.B. Even in the summer Burns and Engelhardt deliver significant teaching packages to classes in several of the schools at Galveston. Thus, some of my most profitable time was spent in observing their teaching program.

I also sat in on several meetings with department and school representatives where Burns and Engelhardt discussed further contributions they might make. I came away convinced that provided the medial humanities are properly conceived and courteously packaged, they will usually be recognized as legitimate scholarly endeavors in a medical center. I must add a couple of additional notes to this discussion of their teaching program. What I observed was the culmination of four years of spadework within U.T.M.B. by Dr. Burns. Also, the humanist at a medical center must guard against overextension to a point of diminishing return. Or, to paraphrase Burns, they were aware that as their program expanded further in future months, they must consolidate and streamline certain parts of their teaching efforts (e.g., common research seminars) lest they collapse from exhaustion before reaching the age of forty.!

A long discussion with Dr. John Bruhn, Associate Dean for Community Affairs, proved helpful in reminding me that humanistic attitudes bridge all specialty areas in academia. A sociologist by training, and previously a department chairman at the University of Oklahoma, Bruhn and I discussed common views on the appeal and value of leading students toward more objective attitudes about their professional discipline in all phases of medical education.

Two other discussions helped me get a better view of our efforts as seen by those outside our specialty. I talked with Dr. Donald Duncan, Ashbel Smith Professor of Anatomy, about his years of effort to keep up interest in the history of anatomy. Similarly, Dr. Alvin Rodin, Professor of Pathology, talked candidly about his efforts to overcome student and faculty inertia toward subjects now relating directly to the main track of training students. Both men noted that they believed they were most successful when they geared the extra (or historical) part of their teaching to specific needs and interests of the students; i.e., biographical and topical presentations relating to what the students were then doing.

All of these discussions helped me, because they dovetailed with some and modified other ideas I had been developing after consultation with faculty in several departments at Tulane.

Obviously I benefited from my total experience even more than I could have predicted in my fellowship application. Interaction with Drs. Burns and Engelhardt as scholars and friends proved so exciting and mutually therapeutic that it merits first mention. It seems pertinent to quote the three summary points of my plan of study listed on page one of my application for the fellowship.

1. Personal Growth - Working with Burns and Engelhardt should challenge and enlarge the intellectual framework I use in developing and expressing ideas.

2. Teaching - Enable a restructuring of my history of medicine elective to include the examination of previous value systems as part of the profession's past.

3. Strengthen the history of medicine office as an interdisciplinary resource, emphasizing humanistic values within the Tulane Medical Center.

I feel that all three points were accomplished, and to a greater degree than I hoped. Some already have been spelled out, and others will be in other parts of this report. However, I can summarize here several things I had not expected:

1. The History of Medicine Division of U.T.M.B. had three summer fellows from different levels of the U.T. system. This allowed a broader approach to the teaching program than I had expected to be possible. A major unexpected blessing was a fantastic dinner at Gaido's, a famous Galveston seafood restaurant, for all the fellows and faculty.

2. Participation in a group of seminars during July centering on historical and philosophical aspects of medicine. The summer fellows reported on some part of their specialty or a special summer project. I gave a report on July 5 on American medical ideas relating to blood in the mid-nineteenth century. U.T. fellows reported on the philosophical bases for John Brown's

medical system, and a questionnaire follow-up on parents who had received genetic counseling over the last several years. A medical student gave a fascinating talk and slide presentation on his hobby of collecting postage stamps featuring medical subjects.

3. Observations of an on-going summer teaching program. Drs. Burns and Engelhardt were engaged in teaching various courses, using their background as physicians and as specialists in the medical humanities, for the School of Allied Health Sciences, and for a special summer program for minority students (Chicano and Black collegians). Close observation and interaction with the minorities group proved especially interesting, since it consisted of a small group (about 20) with extensive contact between faculty and students.

4. My month's observations of the success of Burns and Engelhardt forced me to face the fact that they received added respect and were accepted easily in some situations because of their training as physicians as well as specialists in an area of the medical humanities. This is an obvious point, but it merits careful mention. Since I am not a physician, my conclusion was that I must make a renewed effort to draw ideas and opinions from physician-faculty at every possible opportunity - lunch, committee meetings, etc. - to be certain my ideas are able to have maximum effect through knowing the ground rules of the medical center. This obviously applies to every level of my work in the Tulane Medical Center as an interdisciplinary resource. This fits my personality, since I tend to move toward common ground in discussions and interpersonal relationships, so the month at Galveston helped me shape up my own awareness of my most comfortable role at Tulane.

5. U.T.M.B. Medical Humanities Committee Report - an unexpected boon of incredible importance. This special committee, made up of faculty, students, and Galveston citizens of various training and interest, met under Dr. Chester Burns' direction for an hour each week from October 13, 1971, to May 10, 1972. In some cases it called on outside consultants, such as E. A. Vastyan of the Hershey Medical Center. These meetings were arranged in three broad stages: defining and understanding the disciplines which were involved in medical humanities (religion, philosophy, history, law, languages, literature, and the creative arts); transferring these specialties to the medical center through defining where they had relevance to its educational process; and recommending what actions should be taken for the creation of a medical curriculum at U.T.M.B.

which was more responsive to the needs of the students in terms of professional enrichment and preparation through the teaching of the medical humanities. I found the document very valuable, especially the first and second parts. I spent more than two days reading through the minutes in their entirety. My parting recommendation to Chester Burns was that he consider publication of the minutes, or else writing up a paper describing his experience so that all in the field can profit from the amazing effort at U.T.M.B.

Exposure to the teaching methods of Burns and Engelhardt, and conversation with Harold Levine, Director of Research in Medical Education, have convinced me of the need to shift to a discussion format instead of the traditional lecture in my future teaching efforts. I will use lecturing as a transitional device where helpful, but the thrust of my teaching will center on class participation through outside readings and discussion. In addition, this format will make it easier for me to handle the various historical periods as idea frames, within which medical ideas and values were identifiable but in flux. I will continue to emphasize Lester King's reminder (Growth of Medical Thought, p. 2) that doctors of previous eras "were just as intelligent as we today, and that whatever they said and did, they said and did for good reasons".

As I mentioned in my fellowship application, my history of medicine elective is at present the vehicle for my incorporating human values in medicine into my teaching. But that is not the only impact which my fellowship has had. Being exposed to a variety of teaching experiences has increased my self-confidence. My batteries were recharged, and I am now ready to enter the tangled ideological thicket which exists in any classroom and apply myself to helping students see the value of testing and refining the ideas under discussion. Finally, the close contact with Burns and Engelhardt will affect me professionally in making me a better scholar, and therefore a better resource at Tulane.

Presently I hope three papers will come out of my month of study, research, and reading. Dr. Burns helped me view the history of medical ethics in a broader perspective than was possible before. As a result my publication plans center on evolving intra-professional relationships.

1. Marie Charlotte Schaefer (1874-1927), U.T.M.B.'s first woman member of the Faculty of Medicine. I did new research on her, planning to emphasize that her lack of social and professional life was a product of her period. To be submitted to U.T.M.B.'s Texas Reports on Biology and Medicine late this fall.

2. A comparative study of Schaefer and Mary Elizabeth Bass (1876-1956), Tulane's first woman medical faculty member. I have already published an article on Bass in Tulane Medicine. This essay will be an analysis and description of the women, their times, and the medical and social forces which affected their professional careers. To be submitted to the Journal of Medical Education in early spring.

3. An examination of the ethical issues involved in the evolution of blood transfusion from a specialized surgical procedure to a common tool of internal medicine in combatting fluid loss. This occurred in the twentieth century. I was aware of friction and controversy on this point in the 1930s and 1940s, but after gaining Burns' overview of the history of medical ethics, I now see it as an ethical as well as a technological development. The fact that the shift from direct to indirect transfusion was significant and interesting was reinforced for me when Dr. Truman G. Blocker told of personal experiences with transfusion during the period. To be submitted to Surgery in late spring, since its editor-in-chief, Theodore Drapanas of Tulane, had invited me to submit an appropriate piece on transfusion for consideration by the Board of Editors.

We continue to work hard at Tulane toward developing a formal program in the medical humanities. At present the Division of the History of Medicine is the only formal unit. Student interest is high, and our present informal programs are highly significant. We now have a new Dean, William G. Thurman, and although the severe financial crisis at Tulane is not over by any means, our ship seems to be weathering the storm, and our beginning programs are still afloat, are viable, and promise new growth.

Perhaps the beacon's light in our efforts here at Tulane, because he is the center of student interest in the medical humanities, is James A. Knight, M.D., Associate Dean of the School of Medicine, and Director of Admissions. He hopes that we can formalize a strong medical humanities program soon. For a sample of his commitment to the subject, please see his new book, Medical Student: Doctor In the Making (New York: Appleton-Century-Crofts, 1973). As a labor of love, it accurately reflects his hopes for future sustainment of a high level of humanism in medicine at Tulane.

STUART F. SPICKER

Stuart Francis Spicker was born in the Bronx, New York City, May 14, 1937. He received his primary and secondary education in the public school system of New York City and graduated from the Bronx High School of Science in June 1955. For the next four years he attended the City University of New York at Queens College, receiving his baccalaureate degree in June 1959, having concentrated his studies in philosophy.

Upon graduation he received a commission as a Reserve Officer in the United States Air Force with the rank of second lieutenant. At the time of graduation, he accepted the three-year awards of the Alvin Johnson Prize Scholarship and the National Defense Education Act Fellowship for full-time study with the Graduate Faculty of the New School for Social Research in New York City. During this period he pursued an interdisciplinary curriculum in philosophy and psychology. In June, 1962, he was awarded the Master of Arts in Social Psychology.

Upon graduation from the New School, he was called to active duty with the United States Air Force and was assigned as a first lieutenant to Air University, Maxwell Air Force Base, Montgomery, Alabama. He remained at Air University from July, 1962, until May, 1964; during that period he was employed by the University of Alabama as an instructor of philosophy. He was then reassigned to the faculty of the United States Air Force Academy in Colorado where he taught both psychology and philosophy from August, 1964, until June 1967, having obtained the rank of Captain and Assistant Professor of Philosophy.

While assigned to the Air Force Academy, he was employed as an Honorarium Instructor by the University of Colorado and as an instructor of philosophy of Southern Colorado State College. In June, 1966, he matriculated as a graduate student in philosophy at the University of Colorado, having transferred from the New School in New York City, and was awarded the Doctor of Philosophy degree in June, 1968.

Dr. Spicker resigned his Commission in the Air Force on September 1, 1967, and became a member of the Department of Philosophy of the faculty of the College of Arts and Sciences at the University of Wyoming. During the period from September, 1967, until August, 1969, he was active in University affairs, served with the Faculty Senate, and conducted a weekly radio program dealing with current issues. During his appointment to the faculty of the University of Wyoming, Dr. Spicker completed an anthology, The Philosophy of the Body, published by Quadrangle Books, Chicago-New York City, 1970. (Reprinted, 1973.)

During the academic year 1969-1970, Professor Spicker was a recipient of a post-doctoral fellowship (Cambridge, England) from the National Endowment for the Humanities, which enabled him to initiate research and an original manuscript on the psychopathology and philosophy of the body.

During this period he was released from teaching obligations, and used this opportunity to publish numerous articles and reviews in philosophical journals, and to prepare research materials for publications in the areas of philosophy of medicine and philosophical anthropology.

Upon his return from England, Dr. Spicker accepted the Chairmanship of the Division of Philosophy and Social Sciences at Lea College in Albert Lea, Minnesota. Because of severe financial pressures, Lea College, an experiment in higher education, was not able to continue, and Professor Spicker accepted a post as Chairman, Department of Philosophy and Religion, Coe College, Cedar Rapids, Iowa, maintaining the rank of Associate Professor of Philosophy. During his two years at Coe he served on the Interdisciplinary Committee and the Introduction to Liberal Arts Revision Committee, the latter charged with revising a two-semester curriculum for all incoming students. He served as a key member of the Committee to Revitalize the Humanities at Coe, which was subsequently successful in obtaining a planning grant from the National Endowment for the Humanities.

During the summer of 1973, Professor Spicker received a Fellowship in Human Values and Medicine, awarded by the Institute on Human Values in Medicine. His host during the tenure of his fellowship was the Department of Medicine, College of Medicine, University of Vermont.

On September 1, 1973, Dr. Spicker began a new post with the Department of Community Medicine and Health Care, School of Medicine, Health Center, University of Connecticut in Farmington. He is currently Associate Professor of (Philosophy) Community Medicine.

From July 1 through August 9, 1974, Dr. Spicker will be a participant at the "Summer Institute on Moral Issues in Medicine," sponsored by the Council for Philosophical Studies and hosted at Haverford College, Haverford, Pennsylvania.

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EXPERIENCING A UNIVERSITY MEDICAL CENTER:
A HUMANIST'S "CLERKSHIP"

Submitted by

Stuart F. Spicker, Ph.D.

The tenure of my Institute Fellowship coincided with my transition from a traditional academic position (associate professor and chairman) in a college philosophy department to a new position at the University of Connecticut Health Center. My current appointment carries the title Associate Professor of (Philosophy) Community Medicine. The duties of this position were described in this way by my chairman in his Second Annual Report:

> "Doctor Spicker, who represents the fruition of our effort to identify leadership for the development of this area (Humanistic Studies), will join the Department in July. He will begin his effort with a two-month fellowship awarded by the National Endowment for the Humanities, which will enable him to become familiar with this area in other schools of medicine before beginning at this School. The importance of exploring the interface of advancing science technology and the quality of life is becoming increasingly clear to many of us; we look forward to this development with a sense of excitement" (page 9, "Plans").
>
> James E. C. Walker, M.D.
> Professor and Chairman
> Department of Community Medicine

This paragraph surely points beyond teaching "occasional courses" and instead, indicates the intent of the Health Center to structure a humanities program, multi-faceted, in the next three to five years. I am especially pleased to have been chosen to lead this new development at the University of Connecticut. It is also clear that the infusion of a human values orientation is crucial to this new development. Moreover, an effort is currently being made to infuse the entire University of Connecticut (Arts and Sciences, Law, and Health Sciences) with this ingredient.

With the intention of enabling myself to develop further my philosophical projects based on a unified theory of man, I formulated these gaosl for my fellowship period:

1. To familiarize myself with the communications network in a major health sciences center--i.e., the University of Vermont College of Medicine and its teaching hospitals, the DeGoesbriand and the Mary Fletcher.

2. To gain experience in the medical context of a university center by participating in grand rounds, clinical and pathological conferences, conferences in diagnostic theory (with Dr. Lawrence L. Weed), and the Renal Hemodialysis Training Program (with Dr. Frank McKegney, Jr.)

3. To gain an ability to evaluate the relation that obtains between concrete medical cases as they appear in the hospital setting, and the philosophical ramifications of these cases, some of which will be related to moral philosophy (ethics).

With but a few exceptions, I was able to achieve my original objectives.* First, however, I should like to mention those goals which I was unable to realize:

1. I was not able to gain further understanding of the problems associated with "continuing education," and I did not obtain a set of interviews with George W. Welsh, Director of Continuing Education for the Health Sciences. Although I am not planning to be engaged immediately in working with practicing

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*Since the main thrust of my ten-week program was not research-oriented, as many fellowships usually are, I have not taken the time to write articles, monographs, or other documents based on the actual ongoing summer experience. This was not my view of the proposal which I submitted (for I have already published numerous articles, a book, and intend to continue to do so during my professional life as a member of the faculty of the University of Connecticut Health Center).

I shall prepare a paper called "The Lived-Body as Catalytic Agent: Reaction at the Interface of Medicine and Philosophy" for the First Trans-Disciplinary Symposium on the Interface of Philosophy and Medicine (University of Texas Medical Branch, Galveston: May 9-11, 1974). The title of the symposium is "Evaluation and Explanation in the Biomedical Sciences." As Executive Secretary, I shall co-edit the Proceedings with H. Tristram Engelhardt, Jr. of the Institute for the Medical Humanities at UTMB.

physicians in the community surrounding the Farmington Health Center, I am, of course, concerned to determine whether there is a role for philosophy and the humanities in the general area which goes under the rubric of "continuing education." I have become sensitive to this area after reading articles by Edmund D. Pellegrino, M.D., as well as pursuing the national scope of such programs, by discipline, as outlined in a Supplementary Issue of JAMA (Aug. 13, 1973, Vol. 225, No.7). It is disappointing to note that thus far no program for practicing physicians is offered in (say) the domain of medical ethics. It may be that we must wait a number of years before we shall see developments in this area.

2. I was not able to interact with a wide range of medical administrators. Although I did meet very briefly with the Dean of the College of Medicine, William H. Luginbuhl, M.D., I had the opportunity to contact the Assistant Dean of Medicine, David M. Tormey, M.D. He was very supportive, and enabled me to meet a wide variety of faculty and students engaged in the medical school and its associated hospitals. It seemed to me that Dean Tormey encouraged those elements within his College which showed interest in developing projects which could be clearly associated with the humanistic disciplines.

   I met with a medical student, William Hickey, who earned the M.A. in philosophy, and was currently engaged along with two other medical students in working out a syllabus for a course in medical ethics, to be taught primarily by a group of local visiting faculty from the University of Vermont. So signs of life - at least the vital signs -- are present at UVM; one day we may witness a larger role for the humanities in this medical setting. I was well aware that my role was not that of missionary, but, on the contrary, that of observer in order to enhance my work while at the University of Connecticut.

3. In my judgment, I did not interact with enough patients, as I would have hoped to do. For example, on two separate occasions, I contacted the office of the Chairman of Surgery, John H. Davis, M.D., and was encouraged and told that I would be put under the tutelage of the head resident of surgery in order to follow a patient or two from time of admission to DeGoesbriand or Mary Fletcher Hospital. This never materialized, however. On the other hand, Dr. Roger S. Foster, Assistant Professor of Surgery, did participate extensively in the team conferences in the Renal Hemodialysis Training Program, directed by Dr. Frank P. McKegney, Jr., Professor of Psychiatry. So in fact I did have some interaction with a surgeon, but I hope to accomplish more of this in my permanent position at the University of Connecticut. I feel certain that the Chairman of Surgery did not intend to limit my goals, but I believe that the busy schedule of that Department inhibited my personal objective.

> (I hasten to add that during my first week in Burlington I attended a meeting in North Burlington, a community session in which a group of leading physicians from the College of Medicine played a major role in working with community leaders in planning a separate clinic in this area of the city. I confess that I was surprised to see the Chairman of the Department of Surgery as well as others so personally involved with the community. This should not go unnoticed by those who are so quick to criticize medical practitioners for lack of involvement!)

As I said in my proposal, I planned to be immersed in the on-going activities of the medical setting. I attended many meetings including those of the Department of Medicine, family practitioners in the community who are connected with the College of Medicine as well as the affiliated hospitals, grand rounds in neurology, and a few in psychiatry. I therefore received the support of Dr. Charles M. Poser, Professor of Neurology, and Dr. Hans R. Huessy, Professor of Psychiatry.

However, the majority of my time at UVM was taken up with the Renal Hemodialysis Training Program. This included extensive reading of all materials suggested (and at times loaned) by Dr. McKegney. I have compiled an extensive collection of articles (not only on hemodialysis but also on other related medical subjects (e.g., psychosomatic disease), and I hope to make use of these in working with students at the Connecticut Health Center.

I attended consultations with those persons specializing in renal disease, and I accompanied Dr. McKegney during his interview of a patient as part of the psychiatric interview to determine eligibility for hemodialysis, not only for short-term treatment, but also long-term prolongation of life. Since I encountered both male and female patients, in the training program, I was able to enrich my experience in interviewing not only males (as I did during my VA experience in Kentucky in 1966). I also met some younger patients--e.g., the 16-year-old sister who donated a kidney to her older brother, both of whom are doing well out of the hospital.

I encountered other important persons and programs that left a formidable impression. Perhaps these experiences need not be elaborated here, but I would like at least to mention the following:

> The Problem-Oriented Record and computer-related methods, designed by Dr. Lawrence L. Weed, Professor of Medicine.

Curriculum plans, led by Dr. William Young. He offered me a good deal of insight on educational matters and made me see the role of genetics beyond the narrow view I had originally held.

Renal Disease, chaired by Dr. Carl F. Runge, Assistant Professor of Medicine, who reveals the dedication and care we would hope to see in all medical practitioners.

Dr. Robert B. Lorenz, Director of Instructional Resources, shared his knowledge of audio-visual instructional materials for the humanities concepts which I hope to introduce in my new post.

Dr. Frank L. Babbott, acting chairman of the Department of Community Medicine, aided me in discussing his department and its role in the health center; he also introduced me to other persons in order to expand my knowledge of health science matters. I can mention also the education I received as a patient of Dr. Trace, who, himself a medical student, provided a physical examination under the tutelage of Dr. David Babbott.

Dr. Edward S. Horton, Associate Professor of Medicine, gave me access to an abundant file of materials on the ethics of experimentation on human persons (inclusive of DHEW materials), and expanded my awareness of the wide range of literature already published in this area. As Chairman of the Committee to review Medical Research on Human Subjects, Dr. Horton motivated me to participate in this endeavor on my return to the Health Center at Farmington. (I have already requested the opportunity to serve on the University of Connecticut's parallel committee (McCook Hospital) as well as its Tumor Committee.)

Chaplain L. Udell introduced me to persons and encouraged my participation while at UVM. For example, I spent time with Robert A. Rice, Assistant Professor of Philosophy, and discovered that he had prepared a syllabus on death and dying and had already taught students in the arts and sciences as well as the nursing school.

Finally, I wish to express my gratitude to Dr. George A. Wolf, Jr., Professor of Medicine, for his enduring support and cogent advice and conversation during my ten-week program. Without his help and that of his colleagues, Dr. David Babbott and Dr. William A. Tisdale, my stay would surely have been unprofitable.

I managed to read far more than I had planned when I arrived at UVM. I found the literature quite exciting, yet not terribly profound, since many of the topic-areas germane to my discipline are still undeveloped. Thus I acquired and read numerous articles in the following categories:

1. Renal hemodialysis
2. Psychosomatic disease
3. Experimentation on human persons
4. Death and Dying
5. Economics of health care
6. Concept of disease
7. Medical administration
8. History of medicine
9. Philosophy and medicine
10. Problem-oriented record
11. Various other areas

In all, I read in excess of 125 articles, primarily excerpted from medical journals. I sifted all titles from all back issues of the Bulletin of the History of Medicine and the Journal of the History of Medicine. I had not intended to read the history of medicine during these ten weeks, but the literature in these distinguished journals demanded to be read and collected.

As a result of my Institute Fellowship, I have plans to introduce new course materials into my teaching responsibilties at the Health Center. This point needs qualification: one of the important discoveries of many discussions with medical students is that topics in philosophy may perhaps be best treated by dealing with a limited faculty-student ratio (e.g., 1::1 or 1::2), generating projects for a student or two, and meeting with them on a weekly basis and at irregular intervals and hours. So I cannot say that I shall offer specifically new courses if we take the latter term in the strict sense.

During September and October, 1973, I shall offer to six students a seminar entitled "Philosophical and Psychological Dimensions of Medicine" (see appended syllabus). It should be noted that this "Seminar in Social and Behavioral Sciences" is currently listed along with the social and behavioral sciences, since it is the first seminar taught by a humanist (i.e., philosopher) in the Connecticut Health Center. Additional course syllabi will be forwarded to the Institute when they are prepared to meet the specific pedagogical requirements of programs ongoing in the Health Center.

Having completed my ten-week program at UVM, I certainly feel more comfortable as I prepare to introduce my seminar in the Health Center at Farmington. I should like to register a special mark of appreciation to John H. Mabry, Ph.D., medical sociologist in the Department of Community Medicine at UVM's College of Medicine. Thanks to Dr. Mabry, I was able to meet with nine students of medicine and to engage them in discussion in matters pertinent to my future role in the Connecticut Health Center. Professor Mabry not only enabled me to meet with the students in the medical school, but also arranged a useful and productive luncheon meeting with faculty and administrators.

Discussions with students seemed to reinforce my impression that courses in "Medical Ethics" may not be the best way to introduce the philosopher to the students. "Thanatology," e.g., may be a more interesting topic as an initial subject of inquiry. Too many students (and faculty as well) think of etiquette when they hear "Ethics." Perhaps one should introduce concepts in medical ethics via familiarity with the philosopher's relation to the topic of ethics. So I shall be cautious here and rely heavily on the advice of students who were so cooperative during my stay at UVM.

I can frankly state that I have gained a greater understanding of my own subject (what one might call the concretization of philosophical problems) as a result of my ten-week program. I shall now include aspects of the history of medicine in seminars and lectures. I am not certain that a second position for a humanist ought to be filled by a philosopher or historian of medicine (should our department elect to expand the role of the humanities beyond my initial appointment); for I have come to see the importance of the legal dimension in these humanistic questions. And I shall have to inquire further into that discipline which goes under the heading of "forensic medicine."

I cannot say that my research interests have radically altered because of the fellowship experience. I have some firm ideas in the matter of my publication plans, and they will surely reveal the general effect of these many conversations and literary finds, but I have not abandoned my general plan to publish a major work on medical anthropology which takes as its point of departure a systematic conception of the lived body as the condition of the possibility of all human projects. I should add, however, that I will no doubt prepare some short papers dealing with subjects which I encountered during my ten-week program. I would hope to publish in The Hastings Center Studies, perhaps in JAMA, and similar publications.

THE UNIVERSITY OF CONNECTICUT
Schools of Medicine and Dental Medicine

Social and Behavioral Sciences Subject Committee
First Year
(1973 - 1974)

Stuart F. Spicker

Seminar:
Philosophical and Psychological Dimensions of Medicine

Statement of Objectives

This seminar will explore certain selected dimensions of medicine and the biomedical sciences whose import is philosophical and/or psychological. Notwithstanding the fact that philosophical aspects of medicine are usually viewed as synonymous with so-called "ethical" dimensions of the health sciences and systems of health care, this seminar will not emphasize these moral problems (although we shall touch upon them from time to time), since such problems presuppose a background which this seminar will, in part, begin to provide. Therefore, the following topics will be entertained during the six-week session: (1) the notions of "humanism," "humanists," "humanitarians," and "The Humanities" -- a way out of the labyrinth; (2) the relation between medicine and philosophy disclosed in antiquity; (3) the relation between physician and patient in Western civilization; (4) the psychology of the sickbed; (5) the "patient-world" relation during illness; (6) the psyche-soma distinction; (7) the phenomenon of Man as a bodily-existing being: (8) the concepts of "health," "disease," "norm," and "pathology"; (9) the concepts of "mechanism," "reductionism and "holism"; and (10) the role of the physician as moral agent.

Instructional Methods and Pedagogy

In addition to an introductory session (September 5, 1973, Wednesday) and a closing session (October 13, 1973, Saturday), the seminar will convene for ten two-hour sessions: September 7, 11, 14, 18, 21, 25, 28: October 2, 5, and 9; these are all Tuesdays and Fridays, the sessions meeting from 10-12 p.m.

No formal lectures will be given; rather, the instructor will encourage an open exchange of ideas based on the reading materials assigned for that particular session. Each student will select a topic which is of special interest to him or her, and all will be free to direct their projects and to explore a topic in some depth. The presentations will usually be in the form of a brief paper and, hopefully, a case work-up. A given medical specialty may be brought to bear on the problem area, and the full range of the biomedical sciences will serve as an intellectual base for research investigations. From time to time, a case (either from the literature or generated by on-going events within the health center) will be explored in some detail in order to retain a perspective which is germane to the other facets of medical education in which the student is currently involved.

The visit of an eminent physician-philosopher is currently being planned, and if this materializes, then we should anticipate the visit sometime in late September or early October.

SYLLABUS:

SESSION I: Introduction (no reading assignments)
Wednesday, September 5

A discussion among the participants, including the outline of the syllabus, dimensions of topics, availability of materials, and the relation with the Health Sciences Library.

SESSION II: "Humanism," "Humanists," "Humanitarians," and "The Humanities" -- A Way Out of the Labyrinth.

K. DANNER CLOUSER:
"Humanities and the Medical School: A Sketched Rationale and Description," British Journal of Medical Education, Vol. 5, No. 3 (Sept., 1971), pp. 226-231.

ROBERT J. GLASER, C. D. ARING, E. D. PELLEGRINO, R. M. MAGRAW, O. E. GUTTENTAG: closing remarks, editorial, by E. D. PELLEGRINO.
"Medicine and Humanism: Some Contemporary Views," The Pharos of Alpha Omega Alpha, Vol. 32, No. 1 (Jan. 1969), pp. 2-17.

SESSION III: The Relation Between Medicine and Philosophy in Antiquity
Friday, September 7

WERNER JAEGER:
Paideia: The Ideals of Greek Culture, Volume III, (Oxford: Basil Blackwell, 1945) Chapter I, "Greek Medicine as Paideia," pp. 3-45.

SESSION IV: The Relation Between Physician and Patient
Tuesday, September 11

PEDRO LAIN ENTRALGO:
"The Doctor-Patient Relationship in the General Framework of Interhuman Relationships," excerpted from Contemporary Spanish Philosophy: An Anthology (Notre Dame, Indiana: University of Notre Dame Press, 1967), pp. 250-277. The original Spanish version appeared in La relacion medico-enferme (Madrid: Ediciones de Revista de Occidente, 1964), pp. 235-258.

The doctor-patient relationship in Western Civilization, Doctor and Patient (London: World University Library, 1969).

SESSION V: The Psychology of the Sickbed
Friday, September 14

J.H. van den BERG:
The Psychology of the Sickbed (Pittsburgh, Penna.: Duquesne University Press, 1966)

SESSION VI: The "Patient-World" Relation During Illness
Friday, September 21

J. H. van den BERG:
The Phenomenological Approach to Psychiatry (Springfield, Ill.: Charles C. Thomas, 1955), selected sections. Also, The Psychology of the Sickbed, Chapter I "The Meaning of Being Ill," pp. 23-74.

SESSION VII: An Examination of the Psyche-Soma Distinction
Tuesday, September 25

JULIEN OFFRAY de la METTRIE:
Man a Machine and "The Natural History of the Soul" excerpted from works of the same title (Chicago: Open Court Publishing Co., 1912), pp. 85-86, 128-149, and 153-161. See The Philosophy of the Body, ed. S. F. Spicker, pp. 70-89.

JOHN DEWEY:
"Soul and Body" excerpted from The Philosophy of the Body ed. S. F. Spicker, pp. 101-120. The essay originally appeared in The Bibliotheca Sacra, XLII (April, 1886), pp. 239-263.

SESSION VIII: The Phenomenon of Man as a Bodily-Existing Being
Tuesday, September 18

ERWIN W. STRAUS:
"The Upright Posture," excerpted from Phenomenological Psychology (New York: Basic Books, 1966), pp. 137-165. Also see Psychiatric Quarterly, Vol. 26 (1952), pp. 529-561. The original German version appeared as "Die aufrechte Haltung, Eine anthropologische Studie" in Monatsschrift fur Psychiatrie und Neurologie, Band 117, Heft 4/5/6/ (1949).

HERBERT PLUGGE:
"Man and His Body" excerpted from The Philosophy of the Body, ed. S. F. Spicker, (Chicago: Quadrangle Books, 1970), pp. 293-311. The original German version appeared in Der Mensch und sein Leib (Tubingen, Max Niemeyer Verlag, 1967), pp. 34-42 and 57-68.

SESSION IX: The Concepts of "Health," "Disease," "Norm," and "Pathology"

GEORGE L. ENGEL:
"A Unified Concept of Health and Disease," *Perspectives in Biology and Medicine*, Vol. 3 (Summer, 1960), pp. 459-485.

TAYLOR F. KRAUPL:
"A Logical Analysis of the Medico-Psychological Concept of Disease," Parts I and II, *Psychological Medicine*, Vol. I, No. 5 (November, 1971), pp. 356-364; Vol. II (February, 1972), pp. 7-16.

HORACIO FABREGA:
"Concepts of Disease: Logical Features and Social Implications," *Perspectives in Biology and Medicine*, Vol. 15, No. 4 (Summer, 1972) pp. 583-616.

ERWIN W. STRAUS:
"Norm and Pathology of I-World Relations," *Diseases of the Nervous System, Monograph Supplement*, Vol, XXII, No. 4 (1961), pp. 1-12. Excerpted from *Phenomenological Psychology* (New York: Basic Books, 1966), pp. 255-276.

SESSION X: The Concepts of "Mechanism," "Reductionism," and "Holism"

E.K. LEDERMANN:
Philosophy and Medicine (London: Tavistock Publications, 1970), Chapter I, "Two *Philosophies of Medicine*," Part I: "The Philosophy of Mechanistic Materialism," pp. 3-15.

Ibid., Part II; "The Philosophy of Holism," pp. 16-39.

VIKTOR E. FRANKL:
"Nothing But--On Reductionism and Nihilism," *Science* (1968), pp. 51-57; Discussion: S. Kety, B. Inhelder, F. A. Hayek, C. H. Waddington, J.R. Smythies, P. A. Weiss, and A. Koestler. From *Beyond Reductionism--New Perspectives in the Life Sciences*: The Alpbach Symposium--1968, ed. A. Koestler and J. R. Smythies (London: Hutchinson and New York: Macmillan).

MICHAEL POLANYI:
"Life's Irreducible Structure," excerpted from *Knowing and Being* (London: Routledge and Kegan Paul, 1969), pp. 225-239. Reprinted from *Science*, Vol. 160 (1968), pp. 1308-1312.

SESSION XI: The Role of the Physician as Moral Agent

EDMUND D. PELLEGRINO:
"Physicians, Patients, and Society: Some New Tensions in Medical Ethics," reprinted in *Human Aspects of Biomedical Innovation*, eds. Everett Mendelsohn, J. P. Swazey, and I. Taviss (Cambridge, Mass.: Harvard University Press, 1971), pp. 77-97 and 219-220.

ROBERT W. VEATCH AND WILLARD GAYLIN:
"Teaching Medical Ethics: An Experimental Program," Journal of Medical Education, Vol. 47, No. 10 (October, 1972), pp. 779-785.

SESSION XII: Closing Session: Recapitulation

CASEY TRUETT, ARTHUR W. DOUVILLE, BRUCE FAGEL, AND MERLE CUNNINGHAM
"The Medical Curriculum and Human Values: Panel Discussion," JAMA, Vol. 209, No. 9 (September 1, 1969), pp. 1341-1345.

EDMUND D. PELLEGRINO:
"Human Values and the Medical Curriculum," Ibid., pp. 1349-1353.

Clerkship No. 402051 ELECTIVE IN COMMUNITY MEDICINE
Analyzing Ethical Issues in Medicine

Location: School of Medicine and the University Hospital, Farmington

Committee Members: Stuart F. Spicker, Department of Community Medicine

Additional faculty participating in the elective program will include visiting professionals, professors of moral philosophy, and physicians associated with the University of Connecticut Health Center.

Duration: One month

Months Offered: October and April

No. of Students: Minimum of 3, maximum of 8

Prerequisite: Completion of second year of medical school curriculum (N.B. The Introductory Clerkship is *not* a prerequisite)

Description of Program

Objectives

(1) To provide the student with a forum in which to articulate his or her *reasons* for particular moral choices; (2) to *understand what medical ethics is not*; (3) to enable the student to deal effectively with the *literature* of professional ethicists as well as the appropriate materials selected from medical periodicals which deal with ethical issues in medicine; (4) to engender awareness of the role of *criteria in judgments* in medical ethics; (5) to *analyze* critically the presuppositions involved in the opinions of various professionals concerning moral issues in medicine; (6) to *argue* for a position in a coherent fashion, thus preparing to be more effective in making medical decisions having an ethical set of parameters; (7) to enable the student to engage moral problems in medicine, having developed a *method* of approach to such problems which liberate one from merely emotional intuition, spontaneous decision-making in medical situations, and the necessity to have recourse to an authoritarian role when functioning as a physician in society.

The Moral Issues

The first few meetings will be utilized to enable the students to become familiar with the plethora of moral issues in medicine as well as some methods of approaching them. At the end of this period the group will select those issues that are of most interest. The selection will be made from the following list:

a. codes of medical ethics
b. human experimentation
c. professional secrecy and confidentiality
d. abortion
e. allowing the terminally ill patient to die
f. infanticide
g. euthanasia
h. iatrogenic diseases
i. prolongation of life by "artificial" means
j. control over one's body (i.e., refusing treatment for self and others)
k. organ transplantation and scarce resources
l. the quest for knowledge and justification for its cessation
m. genetic and phenotypic control
    1) eugenics, euphenics, euthenics
    2) genetic manipulation (engineering)
    3) artificial semination and sperm banks
    4) cloning
    5) sex and sex determination

The group will consider:

a. alternative ethical theories
b. the physician as "moral agent"
c. the following concepts: "moral agent," "person," "human existence," "life," "death," "physician-patient relation," "the moral ought," "the prudential ought," "normative judgment," "descriptive judgment."
d. values in conflict--medicine and society.

The Clinical Setting

The students will spend approximately 20 hours with attending physicians and medical records in order to determine cases from which moral issues can be identified. The University Hospital will serve as a place to supplement issues which are disclosed in the medical literature. We must, however, caution that although clinical case problems are certainly appropriate to raising questions of values, it would be a mistake to confine the teaching of medical ethics to this context. Thus the major portion of student-faculty interaction will take place in seminar sessions. During these sessions issues will be raised, deliberations will ensue, and this will prepare students for those occasions in which there is no time for extensive, formal deliberations in the actual practice of the medical art.

The Personal Journal

Students will be expected to maintain a personal journal in which the following will be recorded:

a. notes from seminar discussions
b. resumes from articles read in philosophical and medical publications
c. questions determined by reflective inquiry
d. two case write-ups having both (1) the medical protocol and (2) an ethical protocol written in some detail.

Group Discussion

At least one hour of each session will be devoted to group discussion of the issues raised by the topic, and of ways of evaluating them from various perspectives. The group will continue to delimit the moral issues to be confronted in the class sessions in order to work in depth rather than deal at a superficial level with these issues.

Reading Assignments (The syllabus will be distributed on October 1)

The required reading will be limited to one or two articles for each session; they will serve to provide an overview of the general ethical issues to be raised in group session.

A plethora of articles in both medical and professional philosophical journals are now available, and such materials will be discussed in our opening sessions.

In addition, the Stowe Library is well equipped with books which can assist us in our daily concerns. For example, we might elect to work with a newly-published anthology, "Readings on Ethical and Social Issues in Biomedicine," ed. Richard W. Wertz (New Jersey: Prentice-Hall 1973). A more complete reading list will be presented as issues are identified for analysis.

Case Write-Ups

Each student will be responsible for preparing two case write-ups, calling upon his/her prior training in ICM-I and II. The broader questions--moral issues in medicine--will be included in these write-ups, thereby providing an extensive record and analysis of the patients' problems in all their complexity. In preparing for these write-ups, the student will interview (a) the patient, (b) a member of the patient's family, and (c) the attending physician. The student will have access to the patient's medical record in its entirety. (N.B. All caution will be exercised in the write-ups to maintain the strictest confidentiality about patients' names and other identifying characteristics.)

Elective Schedule

Since the entire month of October is available to students who choose this elective, a concentrated period of reflection and study is anticipated. The student should anticipate reading up to three hours daily, writing in his/her journal for at least an hour, and discussing issues informally for another hour. The group will convene for its first meeting on October 1, 1974 (Tuesday) at 10 a.m. in the instructor's office, B-4 079 Farmington. The seminar schedule will include up to ten hours per week, and not less than 40 hours total time during the month. This time will not necessarily include time for preparing and working up cases and the moral issues pertinent to them, as well as the usual medical write-up. The student (although not yet having attended the Introductory Clerkship) will participate from time to time in attending rounds, in anticipation of recognizing a moral issue in the actual context of patient care. Arrangements will be made with the clinical departments to implement this dimension of the elective program. Although the individual journals will reflect each student's written comments, students will be encouraged (though not required) to submit any reflections in writing that prove of special interest.

SEMINAR: "Language and the Elderly:
Reflections on the Linguistic and
Quantitative Taxonomy of Disease
and Chronic Illness"

April 2 - May 3, 1974

Ten 2-hour sessions for students taking "Growth and Development"

Faculty: Ian Lawson, M.D., Medical Director, Hebrew Home for the Aged, and Associate Clinical Professor, Department of Community Medicine and Health Care; and Stuart Spicker, Ph.D., Associate Professor (Philosophy), Department of Community Medicine and Health Care.

Themes: This seminar will engage and analyze (1) the language which the elderly utilize in describing their health status, (2) the language of the current taxonomy of disease, (3) the language of the medical staff which, though presently striving to become more systematic, is still at the threshold of a complete taxonomy of chronic illness. Ordinary language and technical medical terminology are, in medicine, usually complemented by the language of mathematics -- the quantified formulation of meaning -- which may play an obstructive or constructive role in the preparation of the patient's problem-oriented medical record and the plan for optimum care. The language employed (ordinary, technical, and mathematical) by health practitioners and other health staff, a number of whom will visit and participate in the discussions, plays a decisive and often critical role in the delivery of care and the management of infirmity.

To be sure, medical care of the elderly is not that much different from care of other age groups when serious, disabling illness occurs. It is, rather, the fact that the complexity of illness in the elderly fully exhausts our linguistic capacities as part of the comprehensive demands placed on our collective psyche. Chronic illnesses, then, though especially pronounced among the elderly, where care often takes precedence over cure, provide the basis for learning experiences for students of medicine who may not be familiar with the appropriate criteria for providing optimum health care to those who have reached the penultimate stages of human life.

DEVELOPMENT OF NEW COURSES

LESLIE F. CHARD

Leslie F. Chard, II, was born in Dunkirk, New York, on 2 September 1934. He is married and has three children. He attended Trinity College (Connecticut), where he received the BA in 1956, with majors in English and history, and the MA in 1958. After attending Duke University from 1957 to 1961, he was awarded the Ph.D. in 1962, with a major in English and a minor in history. Following three years of part-time teaching at Duke, he was appointed an Instructor in English at Emory University in 1961, and was promoted to Assistant Professor in 1964. He came to the University of Cincinnati in 1966, where he is presently an Associate Professor of English and where he served as Assistant Head of the English Department in 1968-1970. He has been active in many campus and community affairs: he was the Arts and Sciences College representative to the Faculty Senate and the University Senate, a member of the Correlation Committee of the Arts and Sciences College, a member of the Executive Board of the United Campus Ministries, and of the Editorial Board of Notes from the Garage Door--a local literary-current affairs magazine.

He has been awarded a James B. Duke Fellowship, the Frank L. Weil Fellowship for Research in Religion and the Humanities, and most recently a fellowship from the Institute on Human Values in Medicine. In addition, he has been awarded a number of faculty research grants from Emory University and the University of Cincinnati. Besides many articles in English Romanticism, he has published a recent book: Dissenting Republican: Wordsworth's Early Life and Thought in their Political Context (Mouton, 1972). He has just completed a comparative literature anthology, Criticism of the Romantic Period, and he is nearing completion of a study of Joseph Johnson, a prominent eighteenth-century English medical, political, and religious publisher. His work on Romanticism and on Johnson, in particular, has led him to intellectual history--with a special interest in the relationships between medicine, political thought, and religion on the one hand, and the creative arts on the other. Underlying his work is the assumption (now almost a commonplace in intellectual history) that the late eighteenth century gave birth to what we would now call the modern mind--that is, today's way of perceiving reality. He hopes to show the inter-relatedness of these various areas in the eighteenth century, and to indicate their applicability to modern thought, in a comprehensive study of the idea of the city in England from 1770 to 1850--a project which will be undertaken during a sabbatical year in 1974-75.

Currently Mr. Chard is teaching a seminar in "Human Values and Medicine: A Literary Approach" to students in medicine, nursing, and arts and sciences. He has been able to enlist the participation of a number of colleagues in the medical and para-medical area in Cincinnati, and he has been given much encouragement to continue the course and to expand the offerings in this field. He has been asked to speak to the Department of Psychiatry at the Medical College about his work in human values and medicine, and in the fall he will take part in a Health Care Conference sponsored by the University's Community Health Program. He sees his work in intellectual history and in contemporary human values as inseparable, each one adding an important dimension to the other.

Mailing address: Department of English
University of Cincinnati
Cincinnati, Ohio 45221

Mr. Chard would welcome any suggestions about how research in the humanities may be or has been "grounded" in a practical human values context. More specifically, since texts in creative literature and medicine are almost non-existent, he would be eager to collaborate in or to support any projects in this vein. He would also welcome suggestions for appropriate readings in medicine and human values through literature.

DEVELOPMENT OF A NEW COURSE: "Human Values and Medicine: An Approach through Literature"

Submitted by

Leslie F. Chard, Ph.D.

The purpose of my fellowship was to free me from my normal duties for one quarter, during which I would prepare a course in "Human Values and Medicine: An Approach through Literature."

During my fellowship quarter, my work went about as planned. I read widely, met both formally and casually with a variety of people in the local medical profession, and generally tried to familiarize myself with the different human dimensions of medicine.

After an initial review of some basic texts in medical ethics, the history of medicine, and the health care controversy, I focused my reading on creative literature. Almost immediately I realized that virtually all great creative literature, and not just works explicitly medical, would be potentially applicable to a course such as this. (In fact, the amount of worthwhile literature dealing with the lives of doctors as doctors is surprisingly small.) While it has been exciting to uncover the different possibilities, the extent and variety of ways in which literature could be brought to bear upon medicine, I have had to be more selective and limited than I like in choosing texts for the course. My solutions include centering the course on certain broad categories, and then preparing a set of reading lists appropriate to some of the categories we will not be able to deal with.

I had planned (or at least hoped) to formulate a more coherent body of knowledge during the quarter than I have been able to do. I wish I had more "answers" to show for my work, though of course quantifiable results are not always possible in humanistic disciplines. On the other hand, I am certain that as a result of this quarter's work, I will be able to offer a course of considerable human value to those who take it.

As I have read, I have spent much time compiling categorized lists of the most appropriate creative literature. These lists include both works dealing with medicine at large and those concerned with specific human dimensions relevant to medicine--for example aging, death, poverty, and suffering. Since much of the material I will want to use in the course is not easily available, I am relying on my own xerox collections, particularly of appropriate poems and short stories. In fact, I have made a special point of including a variety of literary types (besides the novel) --poetry, short fiction, drama, autobiography, and even journalism (as in George Orwell)--since a given experience takes on very different appearances when seen through the different forms. I have also attempted to include works from a variety of national cultures, again with the idea of widening the student's perspectives. With few exceptions, however, the works have been limited to the last one hundred years.

In interviewing various members of the medical community, I have again aimed at diversity. I have met with private physicians of various specialities, medical school professors and administrators, psychiatrists, public health officials and physicians, experts in environmental medicine, and a professor of law and medicine. My project has been received enthusiastically--there seems to be a wide and sincere interest in the entire area of health and human values--but I must confess to some disappointment when it comes to specifics, at least in the medical school curriculum. (Two exceptions should be noted: the attempts of certain hospitals to be more human-oriented, and certain departments in the Medical College, such as Psychiatry). Many people I talked with could not get down to anything concrete, leaving me with only a vague feeling that it was "nice" to introduce more of a human point of view to the medical curriculum, but with no how or why apparent. As presently constituted, the medical student's curriculum prevents much instruction in human values.

I should specify one highlight of my interviews. This was Dr. Charles Aring, Professor of Neurology at the University Medical Center and the author of many thoughtful articles on medicine and human values. Talking with him was a real inspiration, and he was able to direct me to a number of other worthwhile sources.

Two less time-consuming but still important activities conclude my list. I discovered that both our main library and the branch medical library were lamentably weak in almost all areas of medicine and human values. I saw to it that our collection was improved and, I hope, made the librarians more conscious of the need to keep abreast of developments in the area. Finally, I have begun to get in touch with programs in medicine and human values at other medical centers. After I compare what is being done at other medical schools, I shall see what can be done about starting one here.

As is implied above, my understanding of this area has been enormously widened, and I now see many possibilities for the mutual enrichment of the humanities and the health professions that I had not previously thought of. One general change in my focus is to see that using creative literature in a medical context does not necessarily entail medical ethics; in fact, explicit treatment of specific ethical issues in medicine is seldom found in creative literature. I now see that the core value of an approach such as mine lies in the realm of insight and understanding, not ethics as such. Through literature, a health professional can come to a deeper awareness of his patients, their backgrounds, and especially of the experiences they are undergoing.

One dimension I had not anticipated was the question of the doctor's own humanity. Before my reading this quarter, my focus was entirely on making the doctor more human vis-à-vis his patients, but not in his own right. The two issues are of course related, but I believe they can each be studied individually. Too, I have come to see that, while medicine does have its unique professional problems, many of them are not fundamentally different from those of other disciplines. The tension between the technological and the human would be one example; another would be the tendency for professional rigor to be won at the cost of human values. I suspect it might be very enlightening to the medical professional to learn that he is not that different from people in other professions; and I can see creative literature playing a very useful role in this regard.

I believe that my fellowship quarter will have an impact on every area of my work. I envision continuing graduate seminars in medicine and human values through literature, open to a variety of students both in the health professions and in the humanities. A course in the history of medicine, through literature, would also be feasible. Courses for undergraduates could focus on the doctor in literature and on specific themes, such as medicine and the environment, the individual and the medical institution, aging, death, and so on. Such courses could even be offered as a variable in the third quarter of our Freshman English Program, thus opening them to any student in the university who might be interested in them.

The effect of my work has already been felt here, just in the greater awareness of the humanistic point of view that I sense. Apparently, many medical professionals were unaware of developments at other campuses in medicine and human values programs. Student response has been particularly gratifying. In fact, one student who had been looking for a means of fusing her interests in medicine and humanities decided, after talking with me and learning that such a field existed, to make it her career.

As noted previously, the fellowship will lead directly to a course I am offering next quarter, Human Values and Medicine: An Approach through Literature. A preliminary course announcement is appended to this report. As of this writing I know that students have enrolled from medicine, pharmacy, public health, and graduate arts and sciences--among those I happen to know of. The course will entail almost entirely creative literature: novels by Camus, Walker Percy, and Solzhenitsyn (Cancer Ward), plays by Ibsen and Shaw, a number of short stories and poems--in the form of my own "anthology"--and several pieces by William Carlos Williams. Student projects will then branch out from these, using a variety of special topics which, taken together, should constitute an intensive yet comprehensive overview of the entire field. The course will also make use of the talents of a number of people in and out of the medical college, particularly in the Public Health and Environmental Medicine areas. We shall have frequent guest appearances in this regard.

I have not worked on any publications during my fellowship period, but I plan to prepare a manuscript after offering the seminar. It would be based on the experiences of both quarters and would constitute a course analysis: model curriculum, rationale, applicability, and potentiality for extension.

COURSE ANNOUNCEMENT

Please announce to interested students that the following course will be offered in the Spring Quarter by Professor Chard of the English Department:

English 15-002-681. Human Values and Medicine: An Approach through Literature. 3-5 graduate credits (as appropriate), Thursdays, 3:00 - 5:00 p.m., Room 207-Medical College.

The course will entail readings in selected contemporary poems, plays, and novels (by such writers as Camus, Faulkner, Kafka, Porter, Shaw, W. C. Williams). The object of the course will be to examine the medical profession, in its various dimensions, from a humanistic point of view, with specific attention to medical ethics and current crises in community and environmental medicine. Units will include: the patient as a human being, the individual and the institution, medicine and the environment, the doctor as a professional, the doctor as a human being. Guest lectures will be given by appropriate members of the University community.

The course is an elective for advanced students in the Colleges of Medicine, Nursing and Health, Pharmacy, and in the Graduate Divisions of Arts and Sciences and Community Planning. One of the merits of the course is expected to be the interaction between people from these different disciplines.

Enrollment is limited. Enquiries may be made to Professor Chard (5079) or the Department of English (5924). The first meeting is Thursday, March 28, 3:00 p.m.

English 681 Spring 1974

HUMAN VALUES AND MEDICINE:

AN APPROACH THROUGH LITERATURE

PRELIMINARY SYLLABUS

Week	Readings	Topic
1.	W. C. Williams, Use of Force	THE DOCTOR AS A PROFESSIONAL
2.	Shaw, Doctor's Dilemma	
3.	Solzhenitsyn, Cancer Ward	THE MEDICAL INSTITUTION
4.	Chekhov, Ward No. 6 Henley, In Hospital Whitman, from Specimen Days	
5.	Camus, The Plague Ibsen, Enemy of the People	MEDICINE AND THE ENVIRONMENT
6.	Orwell, Road to Wigan Pier How the Poor Die	
7.	Aiken, Mr. Arcularis Hemingway, In Another Country Natural History of the Dead O'Connor, Revelation	THE PATIENT
8.	Tolstoy, Death of Ivan Ilych Porter, Jilting of Granny Weatherall	
9.	Percy, Love in the Ruins Turgenev, District Doctor Williams, selections from Autobiography	THE DOCTOR AS A PERSON

LOIS N. MAGNER

Although Lois Magner is now a member of the History Department at Purdue University, her earlier training and interests were in science. She grew up in New York, where her hobbies were reading and avoiding gang warfare. Inspired perhaps by the biography of Madame Curie, she majored in chemistry at Brooklyn College. She continued to read widely during her years at college, and was often encouraged by teachers in the humanities to major in English and literature. She was also encouraged by her chemistry teachers--to major in English. Nevertheless, she continued her training in the sciences at the University of Wisconsin, with a major in biochemistry and a minor in genetics. Her doctoral dissertation was a study of some biochemical aspects of the thyroxine induced metamorphosis of Rana catesbeiana tadpoles. In 1968 she began postdoctoral studies in the Biochemistry Department at Purdue University, on the mechanism of insulin action. During this time, she became interested in studies of the way science has changed with time, and the role science has played in society. Dr. Magner became intrigued by the idea of developing courses in these areas which would be of benefit to students in the humanities as well as the sciences.

In 1973, Dr. Magner joined the History Department at Purdue University. A fellowship from the Institute on Human Values in Medicine allowed her to develop new courses as well as work on her own research interests in the history of genetics and eugenics. She is now teaching courses in the history of the life sciences and history of medicine. In addition, she has participated in interdisciplinary courses which are now developing at Purdue. These courses are aimed at exploring the impact of science and technology on society today and bringing viewpoints from various disciplines to bear on large problems, such as health care, human genetics, the environment, etc.

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COURSE DEVELOPMENT IN THE HISTORY OF SCIENCE

Submitted by

Lois N. Magner, Ph.D.

My readings during my fellowship have taken me beyond my original attempt to attain an historical perspective on medical and molecular genetics. I have been led into more of a study of the history of the eugenics movement in the late 19th century, early 20th century, and its resurgence again today. I am particularly interested in the history of the discovery and understanding of human genetic diseases and the biochemistry of the diseases of "inborn errors of metabolism." Here, I have been particularly impressed by the work of Sir Archibald Garrod--and its appalling neglect. It is, I think, instructive to compare the concrete, specific nature of the metabolic abnormalities Garrod studied and compare them with the better known types of study of human heredity. Here, of course, I am referring to the American school of eugenics and the famous studies of traits such as "criminality, slothfulness, alcoholism, promiscuity, and feeble-mindedness" in the Jukes, Kallikaks, etc.

I am planning to undertake a more systematic study of various human genetic diseases. Of particular interest to me during the fellowship period was the study of sickle sell anemia. I have been collecting references and corresponding with people engaged in the study of sickle sell anemia and the various new attempts at treatment. Much of this material has been incorporated into my teaching. This has helped the students to think about various concepts of health and disease -- particularly, the differences between genetic disease and infectious disease, and the meaning of "cure" and "treatment" for these categories.

Research Plans and Long-Range Goals

Since my studies are not yet at the stage of publishable manuscripts, perhaps it would be best for me to submit an outline of my long-range research goals. I hope to complete some of this work during the summer of 1974.

My overall objective is the analysis of the interaction between scientific and technological advances in human values and public concerns. One especially critical and rapidly developing area of concern is the field of genetics. To understand this area better, I plan to do research on the topics outlined below. Hopefully, this research will help to clarify concepts in the field of human genetics in a manner useful to both scientists and non-scientists.

I. Human Genetics - The Current Debate

   A. Analysis of the new philosophy of eugenics

      1. Information content and conceptual basis
      2. Medical and molecular genetics

   B. Implications of technological progress

   C. Public policy and ethical concerns

   D. Analysis of personnel involved

      1. Scientists vs. non-scientists
      2. Background of scientists involved
         a. Training, research, implicit assumptions

   E. Is there really a new crisis situation in human genetics?

II. Historical Perspectives on Human Genetics

   A. Analysis of present state of the science

   B. Development of medical and molecular genetics

      1. The use of model systems

   C. Sir Archibald Garrod and the concept of "inborn errors of metabolism"

      1. Beadle and Tatum - the "one gene, one enzyme concept"

   D. Interactions, isolation, and confusion which characterize the history of genetics

III. History of Eugenic and Euthenic Movements

   A. The "Nature vs. Nurture" controversy

   B. Examination of how much influence the actual state of sophistication in the science of genetics has had on the values and goals of eugenic movements

   C. Beliefs and values differentiating the scientists and non-scientists involved in eugenics movements

   D. Sources of error in the eugenics movements

      1. Racism
      2. Sexism

Interdisciplinary Activities

Purdue University is developing a series of interdisciplinary courses called the "Man Series." Dr. Richard Grace, Head of the Division of Interdisciplinary Engineering Studies, is the coordinator of this program, which is being funded by the Alfred P. Sloan Foundation. The course in which I have been mainly involved is called "Man and Health Care." Faculty members from five different departments have been meeting weekly to plan this course, as well as to exchange ideas and perspectives pertaining to health care and human values. The course will be discussed below but it might be appropriate to describe the meetings and planning that were necessary to develop a truly interdisciplinary approach to problems of technology and human values in general, and to health care, in particular. I was elected "Lead Professor" of the Man and Health Care group. Therefore, I have been responsible for coordinating the activities of the group and serving as representative to the Coordinating Committee of the "Man Series."

The Health Care group includes a political scientist, a sociologist, a control systems engineer, and an engineer who is a member of the Department of Community Health Services at Indiana University-Purdue University at Indianapolis, and myself (history of science and biochemistry). In addition to the meetings of the Health Care group, there have been several meetings of another group for the course "Man and Human Values." Also, there have been meetings of the entire body of faculty members participating in the Man Series. These meetings have been useful in discussing the overall objectives of the series, the efficacy of interdisciplinary teams and courses, and for interaction between faculty members from different schools who would otherwise have little or no opportunity to meet people from other departments.

My research and teaching certainly have indicated to me the great enrichment that can occur from a meeting between humanists, scientists, and health professionals. The interdisciplinary courses have certainly not been as easy to plan as courses within traditional disciplines. It does take a considerable degree of time and effort to understand the viewpoint of people with different training and outlook. However, in various interdisciplinary groups the experience seems to be that when we agree to discuss a major problem, such as health care, all disciplines are involved in the very broad questions raised. By agreeing to eliminate as much jargon and to jettison as much unnecessary technical detail as possible, members of these groups have been able to learn from each other. This broadening of perspective seem to be very beneficial to students, and opens up whole new areas to them. Although the goal of one of these interdisciplinary series was to "improve the social dimensions of engineering education," the "Man Series" has since broadened its objectives. There is a heavy enrollment of students from the humanities and sciences, as well as the engineering school. The participants feel that in a complex technological society like ours, it is particularly important for non-scientists to be exposed to the methods and outlook of scientists and engineers.

New Courses

The work I have done during the fellowship has allowed me to improve the courses I taught previously ("A History of the Life Sciences" and a seminar in "Science and Culture"), and to plan and introduce new courses ("A History of the Health Sciences" and "Man and Health Care").

Since outlines and reading lists for these courses are appended, I will discuss them below only briefly.

History 496 - A History of the Life Sciences

Since a course outline is appended, I will discuss the course only very briefly. I have now taught this course twice. The course title has been left vague deliberately so that the content can be easily changed in response to student interest and to deal with matters of current concern, as well as material from the history of science. Most of the students who have enrolled in this course have been science majors (probably 90%). More than 60% of them plan to go into health-related fields (medicine, nursing, pharmacy, biomedical engineering, clinical chemistry).

I have found that the framework of a history of science course is an excellent way to introduce questions of human values and technology. Such questions arise very well and naturally from the subject material, and lead to good student interest and discussions. On the other hand, I have found that a more "direct" attempt to raise questions of ethical concerns are actively resisted by most of the students. I have been very pleased with student response to this course.

History 433 - A History of the Health Sciences

This course will be taught for the first time during the spring semester of 1974. A great deal of time during the summer was spent on preparing for this course, since it is a new area for me. Again, the title of this course is also quite vague so that content can be flexible in terms of my own changing interests and student needs. I do not yet know the exact enrollment, or the breakdown as to majors and career objectives of this class.

History 493 - Man and Health Care

I am serving as Lead Professor for this course, which is cross-listed in History, Aeronautics and Astronautics Engineering, Industrial Engineering, Sociology, and Political Science. In addition to the five Purdue professors participating in the course, we have invited some expert guest speakers. Among the invited speakers is the Governor of Indiana, Otis Brown. In addition to being a politician, Governor Bowen is also a physician. Thus, he will be uniquely qualified to discuss the health care problems of the state. This lecture by the Governor will also get the course out of the usual academic lines and into the broader community.

History 516 - Readings in the History of Science and Medicine

I have also introduced a new course description for History 516, as a general seminar course in the history of science and medicine. This course will be introduced in the fall semester of 1974. Because of the open nature of this course, I will be able to cover particular areas of interest in depth every time the course is given. Upper-division and graduate students may repeat the course for credit. For the first offering, I am planning to use the history of human genetics as the theme. There is no course syllabus as yet, but I will be happy to send one in at a later date.

Possibilities for Future Programs

There are several probable avenues through which the kind of work the Society is sponsoring may be incorporated into permanent programs at Purdue.

1. History of Science and Medicine

The History Department is now in the process of studying the feasibility of offering a minor and/or major in the History of Science. The courses now being given in this area are listed in the appended material (Courses in the History of Science, Technology, and Medicine.) As mentioned previously, the history of science provides a very good framework for entering into discussions about human values in relation to medicine, science, and technology. I have been writing to various History of Science and Medicine Departments around the country to obtain information which will help us decide whether this will be a useful option. Some of the students in my courses have expressed an interest in such a program.

2. History and Philosophy of Science

During the past semester I have served on a University committee investigating the need for more courses or for a formal program of courses in the History and Philosophy of Science. No formal action has been taken yet. The committee members felt that the immediate problem to be tackled was lack of communication between the School of Humanities and the Schools of Science and Technology. The possibility remains that some new courses will be given as a result of these meetings.

3. The "Man Series"

The courses being developed for the "Man Series" may be organized into some kind of continuing program after the two-year development period. Part of the initial goal of the project has been achieved: that is, faculty from different departments have worked together in attempts to overcome the usual academic barriers between disciplines. Some of the courses, or new ones, could be continued through existing channels for interdisciplinary teaching. It is likely that some of the courses which so far have aroused student and faculty interest (such as the Health Care course) will continue to be given. The Health Care course has even enlisted participation from outside the University, such as representatives of prison medical facilities and Governor Bowen.

Thus, although the plans for this series are not as yet definite, there is good reason to suppose that the faculty will try to arrange some continuing program in the area of human values and science, technology, and medicine.

Professor Magner

History 496

A History of the Life Sciences

Week	Topic	Readings
1	Introductory Matters: Definitions and objectives	G. Stent, Sci. Amer. 227 Dec. 1973, "Prematurity and Uniqueness in scientific Discovery" V. Weisskopf, Science 176, 138, 1972 "The Significance of Science"
	Biology in Antiquity	Gardner, Ch. 1-3
2	Arabian and Medieval Science The Scientific Renaissance: a) Vesalius to Harvey	Gardner, Ch. 4, 5 Boas, Ch. V, IX
3	b) Paracelsus: Chemistry and Magic	Boas, Ch. VII
	Scientific Societies	Gardner, Ch. 7
4	Microscopes and Microtechnology Nature Lovers and Classifiers	Gardner, Ch. 8 Gardner, Ch. 9, 10
5	The Generation Gap: Preformation vs. Epigenesis Mechanical Systems of Nature (Exam)	Gardner, Ch. 11
6	Catastrophism and The New Geology Forerunners of Darwin	Ernst, Mayr, Science 176, 981 (1972) "The Nature of the Darwinian Revolution" H. G. Coffin, "Creation" Gardner, Ch. 12, 13
7	From Angel to Naked Ape Darwin's Critics Social Darwinism	Charles Darwin, Origin of Species, Ch. 1, Ch. IV (p. 128-130) Ch. XV
8	Cell Theory Microbiology and Medicine	Gardner, Ch. 14 Gardner, Ch. 15
9	Mechanism and Vitalism Physiology and Chemistry	Gardner, Ch. 16

Week	Topic	Readings
10	Heredity: Mendel and his Rediscovery Genetics (Exam)	Gardner, Ch. 17
11	Schroedinger's Question: What is Life? The Phage School	E. Schroedinger, What is Life? Ch. 7
12	Molecular Biology DNA Dogma	J. D. Watson, The Double Helix
13	Human Genetics Is "Eugenics" a Science?	B. D. Davies, Science 170, 1279, 1970 "Prospects for Gnetic Intervention in Man"
14	Biology and the Future	Leon Kass, Science 174, 779, 1971 "The New Biology: What Price Relieving Man's Estate?" Gardner, Ch. 18
15	Biology: Uses and Abuses	

Exams and Term Project

Exams will be compiled with the aid of question lists contributed by the class. Questions will be due one week before the exams.

A term project is required. This may be a paper on any topic of your choice as long as you can demonstrate some reasonable connection to the course. Depending on class size and interests, a demonstration, lecture, or panel discussion may be arranged instead of a paper.

A preliminary report on your ideas for a term project is due at the time of the first exam. Do not hesitate to bring up topics of interest to you. We will try to tie them into the course if possible

Textbooks

Gardner, Eldon J.	The History of Biology
Darwin, Charles	Origin of Species
Watson, J.	The Double Helix
Schroedinger, E.	What is Life?

HISTORY OF SCIENCE JOURNALS AT PURDUE

Archives Internationales d'historie des Sciences

British Journal for the History of Science

Bulletin of the History of Medicine

Bulletin Signaletique, Part 522, Historie des Sciences et des Techniques

Daedalus

Historic Aviation

Historical Studies in Physical Sciences

History of Science Society Newsletter

Isis: International Review Devoted to the History of Science

Journal of the History of Biology

Journal of the History of Medicine and Allied Sciences

Journal of Transport History

Medical History; Devoted to the History and Bibliography of Medicine

Railway and Locomotive Historical Science. Bulletin

Revue d'historie de la Pharmacie

Revue d'historie des mines et de la Metallurgie

Royal Society of London, Notes and Records

Pharmacy in History

Technology and Culture; Devoted to the Study of the Development of Technology

Also useful: Science and New Scientist

Professor Magner

History 433

A History of the Health Sciences

Description: The course will offer a survey of the major features of the historical development of medical care from its beginnings in myth and religion up to the present time. Emphasis will be on the wide variations in historical and cultural definitions of health and disease related to the social and cultural factors affecting the value placed on health and medical treatment.

Texts

1. Clendening, Logan - Source Book of Medical History
2. Dubos, René - Mirage of Health
3. Sigerist, Henry - Civilization and Disease
4. Singer, Charles - A Short History of Anatomy and Physiology from the Greeks to Harvey

Other Readings

1. Jaco, E. Gartly (ed.) - Patients, Physicians, and Illness

2. Kass, Leon - Science, 174 (1970), 779.
   The New Biology: What Price Relieving Man's Estate?"

3. Davies, B. D. - Science, 170 (1970), 1279.
   "Prospects for Genetic Intervention in Man"

4. "Historical Aspects of the Cardiac Pacemaker" - in Science, Technology, and Innovation, prepared for NSF (1973).

5. Young, J. H. - American Scientist, 60 (1972), 318.
   "The Persistence of Medical Quackery"

Recommended

1. Ackerkneckt, Erwin - A Short History of Medicine

2. Burnet, F. M. and White, D.O. - Natural History of Infectious Disease

3. Chase, Allan - The Biological Imperatives: Health, Politics, and Human Survival

4. Darlington, C.D. - Genetics and Man

5. Flexner and Flexner - William Henry Welch and the Heroic Age of American Medicine

6. Foucault, Michel - Madness and Civilization: A History of Insanity in the Age of Reason
7. Haller, Mark - Eugenics
8. Keys, Thomas - The History of Surgical Anesthesia
9. Ludmerer, Kenneth - Genetics and American Society
10. Rosen, George - Madness in Society
11. Rothstein, William - American Physicians in the 19th Century
12. Stevens, Rosemary - American Medicine and the Public Interest

Grading

Grades will be determined on the basis of exams, quizzes, a comprehensive final or term project, and participation in discussion sections. Grading policy will be discussed in more detail in class.

Major Objectives of Course

Student suggestions about their major areas of interest are welcome. These should be brought up early in the semester. Examples of important course objectives include:

1. Knowledge of several definitions of health and disease.
2. Awareness of the wide variations in concepts of health.
3. Understanding of the major factors which affect health.
4. Awareness of various social and cultural factors that influence the value placed on health and the development of a concept of health.
5. Comparison of the "sick role" vs. the "well role."
6. Understanding of the major trends in health care and their implications for the future.
7. Recognition of the need for continued improvement of the health care system.

SELECTED DEFINITIONS OF HEALTH

1. World Health Organization

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

2. René Dubos

"...the real measure of health is not the Utopian absence of all disease, but the ability to function effectively within a given environment."

3. Marston Bates

"Disease and health are polar words: that is, like hot and cold, they have meaning only in relation to each other.... The many efforts to establish a comparable (to temperature) sort of a scale for measuring 'degrees' of health have all failed. One suggestion is that zero, the absolute lower limit of health, is death, that as long as there is some life, there is some degree of health. With such a scale, the upper limit, the maximum level, of health would be the perfect functioning of the organism in all respects, but no satisfactory criterion for this maximum has ever been formulated.

4. Herbert Spencer

"Health is the perfect adjustment of an organism to its environment."

5. Webster's Dictionary

"/Health is the/ state of being hale, sound or whole, in body, mind, or soul; well-being, especially the state of being free from physical disease or pain."

6. Peter Sedgwick

Disease is a social construct - there are no illnesses or diseases in nature. "All sickness is essentially deviancy."

7. Miriam Siegler and Humphry Osmond

Models of eight types of illness have been developed: medical, moral, psychoanalytic, social, psychedelic, impaired, family interaction, conspiratorial.

8. Daniel Callahan

"Health is a state of physical well-being." It need not be "complete" but should be adequate..."without significant impairment of function. It need not encompass 'mental' well-being...; And it surely ought not to encompass 'social well-being....'"

1. Introduction

    A. Outline of course objectives
    B. Definitions of health and disease
    C. Biomedical science: progress and problems

    Readings:
    1. Kass, Leon - Science, 174 (1971), 779. "The New Biology: What Price Relieving Man's Estate"
    2. "The Cardiac Pacemaker"

2. Primitive Medicine and the Myth of the Garden of Eden

    A. Ancient Civilizations
    B. Folk Medicine

    Readings:
    1. Dubos - Chap. 1 (Note: It would be worthwhile to read through the whole book at this time.)
    2. Clendening - Chap. 1 and 2

3. The Greco-Roman World

    A. Sources of medical theory - physicians, priests, and philosophers
    B. Aesclepius to Hippocrates
    C. Alexandria and Rome

    Readings:
    1. Dubos - Chap. 5
    2. Clendening - Chap. 3, 4, 6, 11
    3. Singer - Chap. 1

4. Medieval Medicine

    A. Monastic medicine
    B. Magic and superstition
    C. Plagues

    Readings:
    1. Dubos - Chap. 6, 7
    2. Clendening - Chap. 12 (pp. 76-79 and "On Charms")
    3. Singer - Chap. 3: #1, 3, 4, 8
    4. Sigerist - Chap. 5

5. Renaissance Medicine

    A. Artistic and scientific revolution
    B. Advances in anatomy and surgery
    C. Alchemy, Astrology, Iatro Chemistry

    Readings:
    1. Clendening - Chap. 13, 14, 15
    2. Singer - Chap. 4: #1, 2, 3

6. Triumphs and Disasters of the 17th Century

    A. The work of William Harvey
    B. The microscope
    C. Was the 17th Century comparable to ours?
       Fun and Games: plagues, wars, witch-hunting

    Readings:
    1. Singer - Chap. 5: #12
    2. Clendening - Chap. 15, 21, 22

7. Medicine in the Age of Enlightenment

    A. Clinical medicine
    B. Medical life in the 18th century

    Readings:
    1. Clendening - Chap. 25, 26, 28, 29

8. Humanitarian Medicine

    A. Treatment of insanity
    B. Preventive medicine
    C. Smallpox

    Readings:
    1. Clendening - Chap. 27, 34, 35

9. Science and Medicine in the 19th Century

    A. Relationship between medicine and basic science
    B. Cellular pathology

    Readings:
    1. Clendening - Chap. 38: p. 600 (Claude Bernard)

10-11. Science and Medicine (cont.)

    A. Environment and Disease
    B. Medical life - 19th century

    Readings:
    1. Dubos - Chap. 4, 7
    2. Clendening - Chap. 30

12. The Bacteriological Era

    A. Pasteur and Koch
    B. Impact of bacteriological explanation of disease

    Readings:
    1. Clendening - Chap. 32
    2. Dubos - Chap. 3

13. Surgery and Anaesthesia

   A. Lister
   B. Child-Bed Fever
   C. Anaesthesia

   Readings:
   1. Clendening - Chap. 31, 39
   2. Recommended - Clendening, Chap. 17, 24

14. Medical Science in the 20th Century

   A. The biomedical sciences
   B. Human genetics
   C. Eugenics and euthenics: Is eugenics a science?

   Readings:
   1. B. D. Davies, Science, 170 (1970), 1279. "Prospects for Genetic Intervention in Man"
   2. Louis Lasagna, Science, 166 (1969), "The Pharmaceutical Revolution: Its Impact on Science and Society"
   3. Robert Morison - Science, 173 (1972), 694-702. "Death: Process or Event?"
   4. Clendening - Chap. 42

   Recommended:
   1. Neal E. Miller, Science, 163 (1969), 434. "Learning of Visceral and Glandular Responses"
   2. Scientific American, Sept. 1973 - "Life, Death, and Medicine."
   3. Federation Proceedings, 31 (No. 6, 1972), Part II. "Contributions of the Biological Sciences to Human Welfare."
   4. Fed. Pro., 32 (No. 4, 1973). "The Biochemistry of Disease"
   5. Fed. Proc., 28 (Jan.-Feb., 1969) 160-215. "Choice of Animal Models for the Study of Disease Processes in Man."

15. Medical Science and the Quality of Life

   A. Human rights - human experimentation
   B. Civilization and disease
   C. Quacks and quirks

   Readings:
   1. Dubos - Chap. 7, 8
   2. Sigerist - Chap. 1, 12
   3. Jaco - Chap. 8, #8 - Talcott Parsons, "Definitions of Health and Illness in the Light of American Values"
   4. Young, J.H., American Scientist, 60 (1972), 318. "The Persistence of Medical Quackery"

HEALTH CARE

Some Selected Useful References

I. Bibliographies

1. Science for Society

   American Association for the Advancement of Science 3rd Edition, 1972

2. The Hastings Center Bibliography

   The Hastings Center, 1973

II. Books and Articles

1. The Concept of Health - The Hastings Center Studies, 1, #3, 1973

   a. David Mechanic, "Health and Illness in Technological Societies"
   b. Peter Sedgwick, "Illness - Mental and Otherwise"
   c. Miriam Siegler and Humphry Osmond, "The Sick Role Revisited"
   d. Robert M. Veatch, "The Medical Model: Its Nature and Problems"
   e. Daniel Callahan "The WHO Definition of Health"

2. Lewin, Roger, "Towards Perfect Man," New Scientist, (Oct. 4, 1973), 38.

3. "Application of Control Systems Theory to Physiology," Symposium: Federation Proceedings, 28 (Jan.-Feb., 1969), 46-88.

4. "Choice of Animal Models for the Study of Disease Processes in Man," Symposium: Fed. Proc., 28 (Jan.-Feb., 1969) 160-215.

5. "Who Controls the Future of Science?" Symposium: Fed. Proc., 31 (No. 6, 1972), 1549-1581. Especially: "The accountability of physicians and other scientists to society," D. Greenberg, P. 1459 and "Responsibility of physicians to society," R. Nader, p. 1578.

6. "Contributions of the Biological Sciences to Human Welfare," Fed. Proc., 31 (No. 6, 1972), Part II.

   a. Basic Biomedicine
   b. Clinical Medicine
   c. Dental Science
   d. Food
   e. Population Biology
   f. Environmental Hazards
   g. Marine Sciences
   h. Natural Resources

7. "Biochemistry of Disease"
Symposium: *Fed. Proc.*, 32 (No. 4, 1973).

8. Young, J.H., "The Persistance of Medical Quackery in America," *Amer. Sci.*, 60 (1973), 318.

9. Gould, Donald, "The Mind Surgeons," *New Scientist*, (April 26, 1973), 226.

10. Miller, Henry, "Drugs and Public Morality," *New Scientist*, (Aug. 23, 1973), 402.

11. Morison, Robert S., "Death: Process or Event?" and "Death as an Event: A Commentary on Robert Morison," *Science*, 173 (1972), 694-702.

12. Lasagna, Louis, "The Pharmaceutical Revolution: Its Impact on Science and Society," *Science*, 166 (1969), 1227.

13. Dinman, Betram D., "Non-Concept of 'No-Threshold': Chemicals in the Environment," *Science*,175 (1972), 495.

14. Veatch, Robert M., W. Gaylin and C. Morgan (eds.), *The Teaching of Medical Ethics*. A Hastings Center Publication, 1973.

15. Lynn, K.S. (ed.), *The Professions in America*.
The Daedalus Library, 1967.

    a. James H. Means, "Homo Medicus Americanus," pp. 47-69.
    b. Norman E. Zinberg, "Psychiatry: A Professional Dilemma."

16. *Infant Death: An Analysis by Maternal Risk and Health Care*.
National Academy of Sciences, 1973.

History 493

Man and Health Care

Spring, 1974

Prerequisites: None

Professor in Charge: Lois N. Magner

Faculty Participants:

James G. Anderson - Sociology
Kenneth M. Friedman - Political Science
Madeline Goulard - Aeronautics ans Astronautics
Lois N. Magner - History
Stephen D. Roberts - Industrial Engineering

Description:

This course will examine the critical $70 billion question--the health care system of the United States. A team-teaching approach will allow a broad, multidisciplinary study of the health care system.

In addition to consideration of the contributions of the basic sciences and engineering to medical progress, the socio-economic and political aspects of public expectations with respect to health care will be examined. The components of the health care system, institutions and personnel, will be analyzed in detail. The application of the techniques of systems analysis to securing the optimum utilization of the health care system will be emphasized. We will also focus on the problems of the consumer-patient: his rights and expectations, health maintenance and disease prevention, treatment for disease, accessibility of health care, and financing the health care system. To put the United States system into perspective, we will include a critical comparison with the health care systems of other countries.

Man and Health Care

Readings from: (Paperbacks available in local bookstores)

1. Committee for Economic Development - Building a National Health Care System
2. Strickland - U.S. Health Care
3. Chase - Biological Imperatives

4. Fritchler - Smoking and Health

5. Scientific American, Sept. 1973 - Life and Death and Medicine

6. Other articles and books will be suggested during the semester.

Course Outline

Period 1

A. Administer questionnaire from Strickland, U.S. Health Care

B. Film: What Price Health? (60 min.)

Period 2

A. Film: The Case for American Medicine (Interview with Harry Schwartz) (30 min.)

B. Film: A Crisis in Medical Care (Interview with the President of the AMA)

Period 3

A. Discussion of questionnaire and findings from Strickland

B. Discussion of films

Period 4

Panel Discussion OR Small Group Discussion: What is Health?

Period 5-6

An Overview of the Health Care System

(See Towards a Systematic Analysis of Health Care in the United States: A Report to the Congress, (Washington, D.C.: DHEW, GOP, October, 1972).

Period 7

Changing Needs and Demands

Period 8

A. Acute vs. Chronic Conditions

B. Mental Health

Period 9

A. Consumers: The Patients

B. International Comparison: Who's Doing the Best Job?

(See A. Sommers, Health Care in Transition: Directions for the Future, Chapter 2)

Period 10

Providers: Physicians

Period 11

Providers: Other Medical Manpower

Period 12

Hospitals

Period 13

Hospitals

Period 14

Other components of the Health Care System

(1) Nursing Homes
(2) Pharmacies
(3) Blood Banks
(4) Medical Laboratories

Periods 15-16

Financing Medical Care

Period 17

Politics of Health Care

(See B. Ehrenreich and J. Ehrenreich, The American Health Empire
R. R. Alford, "The Political Economy of Health Care: Dynamics Without Change"

Periods 18-21

The Problem of Public Policy: Cigarette Smoking and Public Policy: A Case Study in Economics, Politics, and Health

Periods 22-25

A. Technology Tools and the Use of the Computer in Health Care Delivery

B. The Role of Industrial and Systems Engineering in the Analysis and Design of Health Care Delivery Systems

Period 26

Case Studies: Using New Tools

Period 27-28

Non-Conventional Medicine

Periods 29-30

Ethical Issues and Basic Questions: A Summary

ROBERT M. MARTINEZ

Robert Martinez, born in Glendale, California in 1943, was raised in Niagara Falls, New York. After receiving a B.S. in biology from Niagara University (1965), he obtained a Ph.D. in genetics from the University of California at Berkeley (1972). His thesis research dealt with the effects of break points in chromosome pairing on interference in Drosophila melanogaster.

Bob became interested in bioethics while serving as a teaching assistant for I. Michael Lerner's genetics course for non-science students at Berkeley. Together with Ben Page, he has developed and taught a course entitled Ethics in Biomedical Research and Health Care Delivery at Quinnipiac College in Hamden, Connecticut. He is a member of the Yale Task Force on Genetics and Reproduction, and has also taught at Wilkes College and Albertus Magnus College. His special interests include the mechanism of genetic recombination, and the ethics of medical treatment of human genetic disease. He would be happy to collaborate with anyone who shares these interests and would like to develop studies in these areas.

Apart from academic pursuits, Bob enjoys cooking for family and friends, reading, and gardening. His agricultural efforts last year were rewarded with a quarter-pound of green beans, six miniature ears of corn, and three watermelons the size and approximate consistency of tennis balls, all grown on only two thousand square feet of land. In an effort to cope with rising food prices, he has this year doubled the size of his garden.

Bob lives with his wife and three children in Hamden, Connecticut.

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BENJAMIN B. PAGE

Benjamin B. Page received his B.A. in Government from Harvard in 1962. After teaching in Haiti, doing peace and civil rights work in the Boston area, and studying in the context of the Christian-Marxist dialogue in Czechoslovakia, he earned a Ph.D. in Philosophy and an M.S. in Urban and Regional Planning from Florida State University.

Later Page spent a year at Meharry Medical College in Nashville, Tennessee, helping to develop a curriculum in Health Planning and acting as co-ordinator of a project to interweave ethics into medical education.

Since 1972 he has been Assistant Professor of Philosophy and of Health Services Administration at Quinnipiac College, Hamden, Connecticut. Concurrently he serves as project director of a health planning effort in Hamden and its five neighboring towns.

In addition to a book on _The Czechoslovak Reform Movement 1963-68: A Study in the Theory of Socialism_ (Amsterdam, B. R. Grüner, 1973), Page has published articles in _Sociologické casopis_ (Journal of the Sociological Institute, Czechoslovak Academy of Science), _Monthly Review_, _Commonweal_, _The Nation_, _Journal of Medical Education_ (co-author), and _Inquiry_. In the near future he hopes to study in the area of ethics in biomedical research and health care delivery in a socialist country, and to do a research project on freedom, the individual, and society.

Page and his wife Monica have four children.

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DEVELOPMENT OF A NEW COURSE: "Ethics in Biomedical Research and Health Care Delivery"

Submitted by

Robert M. Martinez, Ph.D.
and
Benjamin W. Page, Ph.D.

Our joint fellowship was directed toward, and its tenure contained, the teaching of a new course at Quinnipiac College during the fall semester of 1973. Its projected title was "Ethics in Biomedical and Behavioral Sciences." As we explained in our proposal, our purpose in requesting a fellowship was to enable us to devote full time during the summer of 1973 to preparing the course and ourselves.

Our proposal indicated plans to study ethics in relation to biomedical and behavioral sciences under the direction of Margaret Farley and David Duncombe of Yale, and to undertake a limited number of visits to consult with other people working in bioethics. Because of the summer vacations of many of these people, most of our study was undertaken on our own. Duncombe and particularly Farley did provide valuable assistance in sorting through and evaluating the large body of potentially pertinent literature, helping us direct attention to the more significant articles and books.

We were also able to complete a number of visits: Professor Michael Munk, SUNY-Stony Brook; Dr. Robert Veatch, Institute of Society, Ethics, and the Life Sciences; and (Martinez) Warren Reich and Leroy Walters, Kennedy Center for Bioethics at Georgetown University. In addition, one of us (Page) was able to sit in on one of Veatch's classes at Manhattanville College in New York and attend the Society's annual meeting during the AAMC convention in Washington. While all of this was helpful, and while our own summer work was personally rewarding and invaluable in preparing the course, we could have benefitted (and still would) from a more systematic approach to the course content and a more extensive exposure to teaching methods used elsewhere.

After we had prepared a preliminary syllabus, we sent it to several members of the Society as well as to medical school and philosophy institutes in various other countries, requesting criticisms and suggestions. Apparently our cover letter did not accomplish what we had hoped it would: we received over 30 replies, but most were of the congratulations-and-good-luck sort. The most serious-sounding response came from three Soviet philosophers (a translation is appended). Unfortunately, the letter did not arrive until early December, too late to be of much specific help during the course or the fellowship period. However, we intend to pursue further this and other contacts.

Additional contacts were established in Czechoslovakia while Page was there on a family visit during the Christmas vacation. Specifically, contacts were established with the Philosophy Institute of the Academy of Science and the Institute of Social Medicine of Charles University's Medical School. Information about other groups involved in ethical questions in medicine in Brno and Hradec Kralovy was gathered, along with various articles on the subject written both before and after the socialization of Czechoslovakia's medical system. Hopefully, these contacts can also be pursued.

Our time percentages work out roughly as follows:

a) at Quinnipiac - 85%
b) at other US institutions - 15%
c) at foreign institutions (not on "fellowship time") (Page) - 10%

One of us (Martinez) is a biologist specializing in genetics, and the other (Page) a philosopher with additional background in health planning. With such complementary disciplines there was considerable "cross-fertilization" as a result of our reading, rap sessions, and course planning work over the summer. Each of us was able to expand and deepen his awareness of the disciplines of the other, as well as gain new insights into his own through on-going dialogue. We intend to keep this dialogue going, not only between ourselves, but on a broader basis as well.

More specifically, many persons who were involved in the course believe that such an isolated, one-shot exposure is not likely to be of significant long-term value. Two proposals are under consideration:

1. A proposal to invite all interested faculty and students to participate in periodic non-credit discussions or seminars on issues relating to ethics in biomedical research and health care delivery. Such a series might become the nucleus of an on-going seminar approach to giving students and faculty a chance to explore ethical issues in the course of their work in health-related subjects. It would also help us discover other faculty whose interests and perspectives might make valuable contributions to the course.

2. The curriculum committee is currently considering a proposal to develop a program in ethics. This would consist of a core of co-ordinated courses dealing with ethical theories and problems from the perspectives of philosophy, psychology, cultural anthropology, sociology, and political science. Then, as students became involved in their various majors (Quinnipiac has in addition to the School of Allied Health and Natural Science and School of Liberal Arts, a School of Economics and Business), this core would be supplemented with seminars of the sort described above.

It should be noted that our course (Bi 205/Pl 222) is officially listed in the college catalogue and will be offered again during the fall of 1974.

The original concept of the course is indicated in the attached outline. There were few substantive changes by the time it was offered, although one of the emphases was changed, as reflected in the title change: it became "Ethics in Biomedical Research and Health Care Delivery."

On the whole, we felt that our course went somewhat awkwardly for several reasons. The class met one evening a week for three hours. In retrospect, we feel this was too long a session and too late a meeting time. Since neither of us had ever taught or been exposed to a course of the sort we wanted to teach, we were at times in a position of having to grope. The early weeks of the course were somewhat overloaded with foundational material. In order to avoid the problems of coordination intrinsic to the guest lecturer approach, we attempted to handle most of the course ourselves. If our own ethical perspectives and human commitments had differed, this might not have presented a problem, but our responses to issues and the ways we worked with them became a bit too predictable. Toward the end, we did try to branch out somewhat: we had one guest lecturer, went on one field trip, and were invited as a class to sit in on one of David Duncombe's ethics seminars at Yale to hear Jay Katz and Robert Levine. Student reactions were mixed and, unfortunately, snow cancelled our final class.

As a result of having taught the course, we are better prepared to teach it in a way that will fit the needs of our students. We have solicited student opinion concerning all phases of the course, but have not yet received all of the expected replies. For this reason we are unable to report on the student evaluation of the course, but will submit a supplementary report at a later date.

Another positive result of having taught the course is that one of us (Martinez) has incorporated ethical considerations into undergraduate courses in general biology and genetics, and a graduate-level course in the recently approved Master of Health Science program.

TRANSLATION

Dear friends:

Thank you very much for your letter. We familiarized ourselves with great interest with your research program and the course content.

We especially liked the didactic side of the course and the idea in itself of studying general and professional ethics - a subject especially important to physicians and other specialists (biochemists, psychologists, radiologists, and others) working in the medical field.

We gladly respond to your request and, in accordance with it, would like to answer in two parts: 1. Comments to the course suggested by you. 2. Our experiences in the study and teaching of philosophical and ethical problems in the field of medical science and medical practice.

I.

First of all, it appears to us that the extremely large number of problems and their complexity would require 3 to 4 times as many sessions than envisioned by you. Furthermore, of those topics (questions) indicated in your program, a number of them (about half) do not have a direct relationship to general medical ethics and deontology, but rather refer to the areas of philosophy, anthropology, sociology, psychology, biology, and other sciences. This refers, primarily, to the problems of population growth, ecology, etc.

We could suggest to you either to reduce the number of topics (questions) by selecting those which are directly related to ethics and to schedule them clearly over 15 sessions; or to increase the number of sessions and, in such a case, to change the title of the course, e.g., to: "Basic philosophical, sociological, ethical, and psychological problems of contemporary medicine."

Secondly, the general course title, "Ethics in the biomedical and behavioristic science" (check English original - Tr. note), evokes some puzzling questions. Why only in science and not in the practical activity of a physician and the system of health services? After all, this side of ethics is more important on the medical as well as on the social levels. Why only in two sciences? This especially in view of the fact that behaviorism is not an independent science, but one of many trends and currents in contemporary American psychology and psychiatry.

Thirdly, also at issue is the singling out of such problems as "the biological evolution of man," "population and ecology," "genetics and sexuality in the behavior of man," "ideas of R. Dubo (DuBois? - check English original -Tr.note) and others.

There exists a vast literature, a large number of publications (including in the English language) where reasoned scientific arguments are given for different contradictory ideas.

In addition such a wording as, "The state of health services in the USA and the 'crisis' of the other (9) health service systems," raises objections on our part. After all, you and your students are well aware of the actual conditions of the health service system in the USA.

Also, it might be desirable to acquaint your students with the conditions of health services in the USSR and in the other socialist countries. May we remind you that the achievements of socialism in this matter have been consolidated in corresponding laws of our government.

Fourthly, concerning your request for suggestions from our side regarding a bibliography and audio-visual methods in the given area, it must be said that the list of scientific works concerning problems of morals and ethics published in our country is very extensive. Only in the field of medical ethics and medical deontology, one could name several tens of thousands of articles, pamphlets, and books. The more interesting works are: D. I. Pisarev, "Ethics and thoughts of the Soviet physician" (1963); S. S. Wail, "A few questions of medical deontology"; N. V. Elshtein, "The physician, the patient, and time"; A. P. Gromov "Medical deontology and the responsibilities of medical personnel"; Zavilenskij, "Physician and patient"; N.N. Petrov, "Questions of surgical deontology."

In our fiction, there are many novels and stories where, in one way or another, problems of medical ethics are analyzed (Veresajev, Chekhov, German, Popova, and others). Scores of films and hundreds of documentaries (dia-films ? Tr.-note) are devoted to the work of physicians.

Concerning your non-fiction literature in this subject area, we could mention the works of M. D. Mechanic, 1968; J. May, 1968: William, M. Kissu...(check original - xerox unclear - Tr.note), 1970; J. Ferry, 1964; K. Dunn, 1957; and especially N. Means Doctors (check original - xerox not clear - Tr.note) 1955: and others, which expose the social causes of man's illnesses and medical activities and the socio-ethical problems connected with it.

In American fiction one can mention the story "The final diagnosis" by Arthur Haley, which was published in our journal, "Science and Life" this year; as well as U. Penfield's novel "The Torch" about the life of Hippocrates, and which has been translated into Russian.

II.

Furthermore, permit us to mention to you a few basic trends in the work of our Department in the area of medical theory and methodology, medical ethics and health services.

Instructors in our Department give lectures and conduct seminars in Marxist-Leninist philosophy during the second year of the medical, sanitary-hygienic, and pharmaceutical schools. While studying the philosophy course, students acquire a knowledge of the most important philosophical questions of medicine as well as the problems of medical ethics and medical deontology. Likewise, instructors of this Department give lecture courses for graduate students and conduct with them seminars to prepare them for the post-graduate examinations.

The Department conducts its scientific research program in two basic, compound areas: 1. Philosophical and methodological problems in the natural sciences and in medicine. 2. Scientific principles in developing the methodology for the teaching of a course in Marxist-Leninist philosophy and the foundations of scientific atheism in the medical institute.

In working on the first group of problems, the staff of this Department investigate the various aspects of the most urgent methodological problems in medicine and the health services. Each year a concrete topic representing one aspect of the general problem area, selected by the Department of Long-term Problems, is studied in depth.

Here are a few of these topics: "The relationship of the social and the biological in medicine." "Methodological principles in the definition of the term 'diseases of man.'" "The scientific-technical revolution and medicine." "The scientific-technical progress and the problem of social and biological adaptation of man." "Social causes of health and diseases in men." "Diseases of civilization." "The significance of the philosophical legacy of the classics of Marism-Leninism for the development of the theory of medicine and health services." "Humanism and medicine." "Problems of medical ethics." "Existentialism in foreign psychiatry." "Psychosomatic diseases and problems of emotional stress." "Social foundations of human genetics." "Methodological problems of diagnostic theory."

In our pedagogical and scientific work we give great consideration to questions of medical ethics and medical deontology. Students and graduate students write reports, read papers at scientific conferences; whereas our teaching personnel are engaged in extensive scientific research work.

Our Department implements and directs complex research projects in the area of medical theory and methodology, medical ethics, in cooperation with other medical departments. Instructors of this Department publish articles in medical journals. Scientific-theoretical conferences are organized concerning urgent philosophical and theoretical problems of contemporary science (including medicine).

An important role in the work of this Department is played by scientific student groups working on the following topics:

"Problems of medical ethics and medical deontology."

"Esthetics and medicine."

"Critique of philosophical and sociological trends in foreign medicine."

"Atheism, religion, and medicine."

These groups are under the guidance of qualified specialists in each of the indicated areas: professors, docents, and senior instructors.

During such group meetings, students' findings and reports as well as papers by the leaders of those groups are discussed. Such an exchange of scientific information promotes the development of student research in the areas of philosophical science, methodological problems in medicine, and heightens students' interest in the study of social sciences.

The work in these groups promotes student interest in philosophical methodology, in the theory of health services and medicine, helps to educate future medical doctors who are in full command of their specialty.

On the instructions of the Department of Marxist-Leninist Philosophy of the I. M. Sechenov First Moscos Medical Institute.

Chairman of the Department of
Marxist-Leninist Philosophy
Candidate for the Ph.D.
Docent /signature/ /Goncharuk, S.I./

Professor /signature/ /Tarasov, K.E./ Ph.D.

Docent /signature/ /Kelner, M.C./ Candidate for the Ph.D.

ETHICS IN BIOMEDICAL RESEARCH AND HEALTH CARE DELIVERY: BI 205/PL 222

PRELIMINARY INFORMATION

COURSE FORMAT: Meetings once a week on Monday evenings from 7:40 to 10:30, plus occasional optional field trips for those able to participate. The Monday evening classes will usually consist of short presentations by the instructors or guests and occasional films followed by discussions, case studies, role-playing situations, student presentations, etc. in small discussion groups. Students will be randomly assigned to discussion groups and will stay with the same group throughout the course. Each instructor will spend time with all groups.

PREPARATION: The readings assigned or distributed for each topic should be read before the class meeting on that topic (the only exception, obviously, is the readings pertinent to the first meeting). Most of the readings will be found in Readings on Ethical and Social Issues in Biomedicine, edited by Richard W. Wertz (available in the bookstore. Students will also be asked to pay $5.00 each to cover the costs of duplicating required readings not included in the Wertz book).

GRADING: There will be no exams or quizzes. Grades will be based on several factors:

a) Each student will keep a weekly journal in which his own critical responses to articles, discussions, presentations, etc. will be kept. These journals are not to be merely class and reading notebooks, but are to contain your own thinking on the topics under consideration and your efforts to integrate the topic and your ideas with other aspects of the course. These journals will be handed in periodically, and must be done by each student individually.

b) Either individually or in groups of two or three, students will submit three short (5-page) papers developing and critically exploring issues raised that particularly interest them. These are not to be research papers and may be expansions of work already included in the journal. The first of these papers will have an assigned topic and will be due between the fourth and fifth meetings. The topics of the other two will be up to you, but should be discussed with one of the instructors before being written. The instructors should also be told in advance of paper hand-ins, the names of people planning to work together, etc.

c) Students will be given at least one opportunity to share in the preparation and leading of the discussion groups to which they are assigned.

NOTE: Students may use formats other than a written paper or formal presentation for items b. and c. With prior consent of an instructor, students could make films, put on a guerilla theatre, or whatever else they believe would convey what they wished to say.

d) At the end of the course students will be asked to indicate what they believe to be a fair grade based on what they have put into the course and obtained from it. The instructors will discuss with each student what they believe to be a fair grade, and arrive at a final grade for the course.

In general, the criteria for grading all instructor-graded work will be:

D Basic familiarity with topics, articles, discussions, etc. as demonstrated by adequate reporting thereof.

C Understanding and critical exploration of topics, etc. as demonstrated by evaluation of and critical responses to the topics, etc. and the exploration of the reasons for your response and evaluation.

B Understanding of the interrelationships among topics as demonstrated by the ability to explore and integrate the ramifications of the various topics.

A Excellence in all of the above

OFFICE HOURS: Both instructors will be in the snack bar on Mondays from 6:30 to 7:30 for informal office hours and raps. Students wishing additional conference time may make arrangements with the instructors.

R. Martinez
office T-6
mail box 130
campus extension 301
home phone 288-4905 (no morning calls, please)

B. Page
office T-8, room 6
mail box 163
campus extension 324
home phone 484-0861

COURSE OUTLINE

Sept. 10 INTRODUCTION TO THE COURSE AND THE ISSUES
- Wertz, "Introduction" in *Readings on Ethical and Social Issues in Biomedicine*, Prentice-Hall, 1973.
- Kass, "The new biology: what price relieving man's estate?" in Wertz.

Sept. 17 LIFE, EVOLUTION AND DEATH
- Dubos, "Man's Nature" from *Man, Medicine, and Environment*. handout

WHAT IS IT TO BE HUMAN?
- Fletcher, "Indicators of humanhood: a tentative profile of man" plus letters in response to this article. handout
- Eisenberg, "The *human* nature of human nature." handout
- Wallace, "Man's humanity." handout

Sept. 24 HUMAN VALUES IN DECISION MAKING
- Jonas, "Philosophical reflections on experimenting with human subjects" in Wertz.
- Callahan, "The sanctity of life." handout
- Ramsey, "Moral and religious implications of genetic control" from *Fabricated Man*. handout
- Gustafson, "Basic ethical issues in the biomedical fields." handout
- Rahner, "Experiment man." handout

Oct. 1 WHO SHALL SURVIVE
- film "Who Shall Survive?"
- Assignment: a paper of about five pages developing, exploring, and criticizing *your own* model of man and the ethical guidelines that follow from it

  OR

  Compare the Ramsey and Rahner articles, indicating which point of view is more similar to your own and why.

Oct. 8 HEALTH CARE DELIVERY
- Michaelson, "The coming medical war" in Wertz.
- Health/Pac: Special Report. handout

Oct. 15 WHY DO BIOMEDICAL RESEARCH?
- Biomedical research 1973: Cancer, heart disease, and everything else. handout
- Levine, "Fundamental and applied research in agriculture." handout
- "Biomedical research (II): "Will the 'wars' ever get started?" handout
- Watson, *The Double Helix*, excerpt. handout

Oct. 22 OUR GENETIC PREDICAMENT

Oct. 29 HUMAN RIGHTS, SOCIETY, AND MAN
- Rabkin, "Your rights as a patient: A vital part of humane medical care." handout

Nov. 6 POPULATION AND ECOLOGY
- Callahan, "Ethics and population limitation." handout

Nov. 13 BEHAVIOR MODIFICATION
- London, "The ethics of behavior control" in Wertz.

Nov. 20 HUMAN EXPERIMENTATION
- guest speaker, Dr. Berkun.

Nov. 27 DEATH AND DYING
- Class held in Beecher and Bennett Funeral Home.
- Fletcher, "Our shameful waste of human tissue." handout
- Morison, "Death: Process or event?" in Wertz
- Kass, "Death as an event: a commentary on Robert Morison" in Wertz.

Dec. 3 RESERVED FOR STUDENT PRESENTATIONS

Dec. 12 HUMAN EXPERIMENTATION
- Visit to David Duncombe's class at Yale.
- Levine, "Ethical considerations in the publications of the results of research involving human subjects." handout
- Katz, "The regulation of human research - reflections and proposals." handout

Dec. 19 CANCELLED BECAUSE OF BAD WEATHER

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